CHEMIST & DRUGGIST

THE NEWSWEEKLY FOR PHARMACY

COUNTERPART

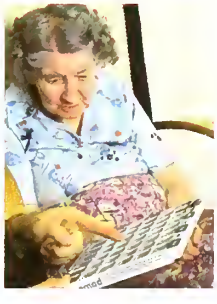
C&D/WHITEHALL LABORATORIES PHARMACIST BRIEFING

18 May 1996

N Yorks pharmacy faces GP challenge

Prescribing intervention a success in Welsh trial

Update: palliative care in perspective



Practice research key to the 'New Age'

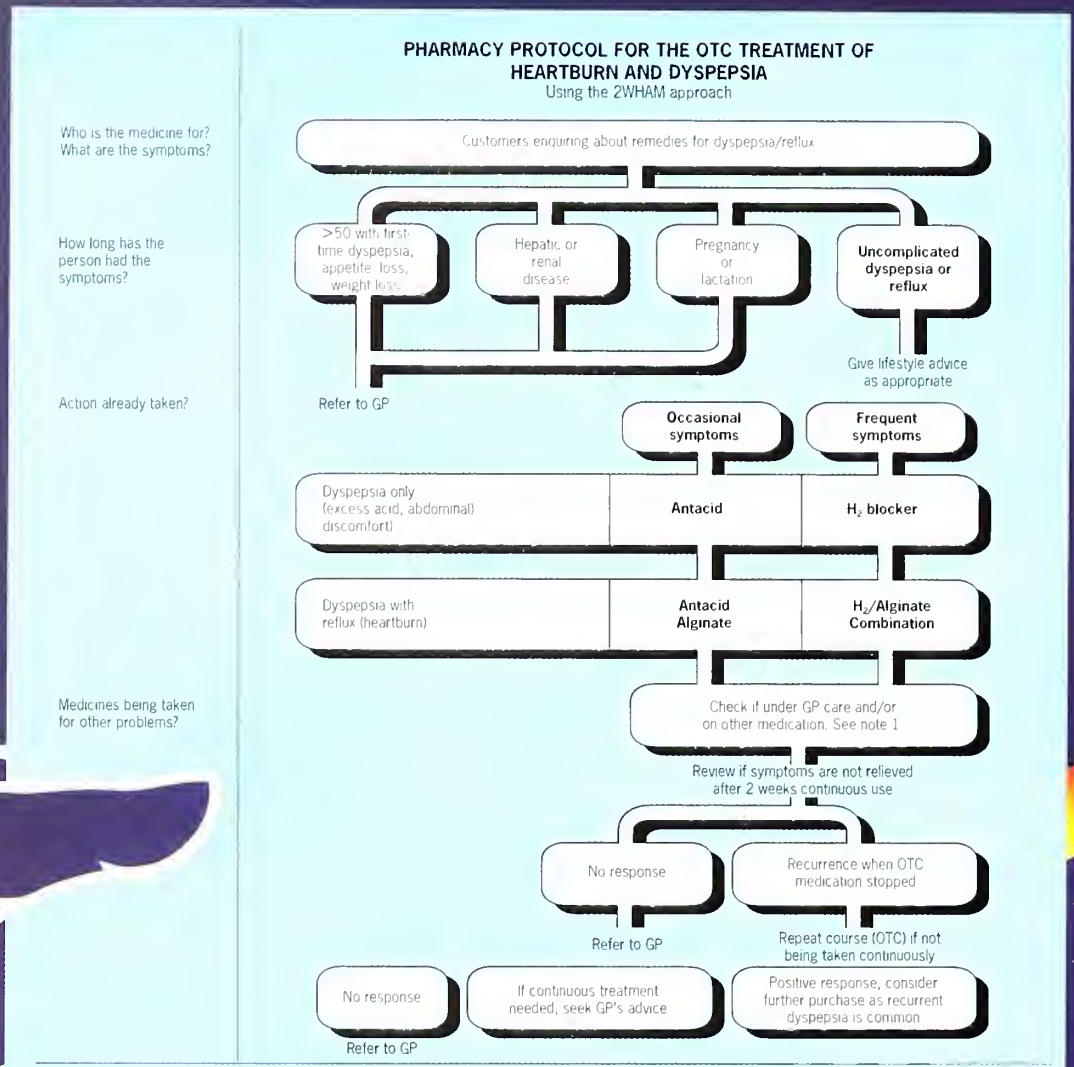
UCA told of three ways pharmacy might go ...

Boots promotes town centre management

Out & About: speaking from the pulpit

Online at http://www.dotpharmacy.com/

A PRACTICAL PROTOCOL



Note 1. In all cases, check if patient is currently taking other medications, especially if under direction from the GP. Some antacids are contraindicated for use with tetracyclines and anticoagulants, and all H_2 blockers are not recommended OTC to patients who are on other medications.

With over 14 million sufferers of reflux and dyspepsia in the UK, this new pharmacy protocol has been written by Professor Duncan Colin-Jones and Dr Jeremy Barnes as a service to pharmacists..

For the treatment of heartburn, it is significant to note that Tagamet Dual Action Liquid is the **only** liquid H_2 antagonist/alginate combination available OTC. Providing fast-acting, long-lasting relief, Tagamet Dual Action Liquid is appropriate first line therapy for heartburn sufferers.

For further information and a full copy of the Protocol, Freephone the OTC Tagamet Information Line – 0500 100 222

RECOMMEND

Tagamet

DUAL ACTION LIQUID

sodium alginate/cimetidine

ECLIPSES EXISTING RAFTING AGENTS

Tagamet Dual Action Liquid. Product Information: Presentation. A white suspension with an odour of fruit and mint containing 500 mg sodium alginate B.P.C. and 200 mg cimetidine per 10 ml dose. **Use.** Short term symptomatic relief of heartburn, associated with acid regurgitation, especially if provoked by bending over or lying supine. **Dosage and administration:** *Adults (incl. the elderly), children 16 years and over.* 10 ml suspension when symptoms appear. If symptoms persist for more than 1 hour after the first dose, a second dose (10 ml) may be taken, but no more than 2 doses in any 4 hours and no more than 4 doses in any 24 hours. Treatment should not be continued for more than two weeks. If symptoms persist for more than two weeks or recur regularly, a doctor should be consulted. Not to be given to children under 16 years of age. **Contraindications.** Hypersensitivity to cimetidine or any of the other constituents. **Precautions.** Not recommended in patients with impaired renal function, hepatic impairment, taking oral anticoagulants, phenytoin, theophylline, intravenous lignocaine, middle aged or older patients with new/changing dyspeptic symptoms, any patients with unintended weight loss and dyspeptic symptoms, because of potential delay in diagnosis of gastric cancer; with compromised bone marrow; in pregnancy and lactation. Use only on a doctor's advice in patients: with any other illness, using any medication, under medical supervision for other reasons, with a history of peptic ulcer who are now using NSAIDS especially the elderly. Contains 66 mg sodium per 10 ml dose and this should be included in the daily allowance of patients on sodium restricted diets. **Adverse reactions.** Diarrhoea, dizziness, rash, tiredness. Gynaecomastia, occasional liver damage, confusional states (usually in the elderly or very ill), all reversible. Rarely thrombocytopenia, leucopenia, agranulocytosis, all reversible. Very rarely, hepatitis, interstitial nephritis, acute pancreatitis, headache, myalgia, arthralgia, fever, sinus bradycardia, tachycardia and heartblock, all reversible, aplastic anaemia, pancytopenia and anaphylaxis. Reports of alopecia and very rarely reports of impotence but no causal relationship has been established at usual prescribed therapeutic doses. **Product licence number** 0002/0232. **Retail price** (200 ml) £4·99. **Legal category** P. **Date of preparation** 8 June 1995.

SmithKline Beecham Consumer Healthcare,
SB House, Brentford, Middlesex, TW8 9BD.
Telephone number 0181 560 5151.
'Tagamet' is a trademark.

SB SmithKline Beecham Consumer Healthcare

COMMENT

The advent of large supermarkets with in-store pharmacies is a retailing trend that Northern Ireland has been spared until now. But, with Sainsbury having two potential sites under development, that is about to change. Barry Andrews, managing director of Moss Chemists, speaking at the Ulster Chemists' Association conference last weekend (see p698), tried to impress on those present the impact such superstores have on High Street trading, and pointed to three ways a pharmacy might evolve in such a situation. 'Managed decline' is not an option many businessmen would be happy to contemplate. Driving an existing business harder or developing new business are surely preferable options, even if the results are less certain.

There is, though, another option to counter the threatened drift of trade to the local superstore, and this is one investigated by Boots, assisted by 22 other leading High Street multiples (see p700). These are retailers who are not big enough to move out of town on their own, but are obviously concerned about a decline of footfall in the High Street (as indeed, and somewhat belatedly, is the Government). Town centre management, where local authorities and businesses set up schemes to promote the in-town shopping facilities, is a concept we could be hearing a lot about in the future. There is firm evidence that in towns where such schemes exist the effect of out of town developments is minimised and the town centre is re-invigorated. TCM is not just for the multiples: a town centre in decline is a concern for every retailer located there. However, the effectiveness of TCM schemes is being inhibited by a lack of funding and a low level of support from local businesses. Is this another example of independent retailers failing to pull together for the common good?

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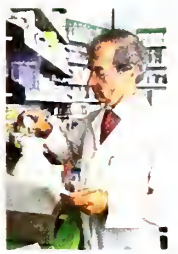


REGULARS

Dispensing GPs fight to stop N Yorks pharmacy opening...

Eight North Yorkshire rural GPs are battling in the High Court to stop a new pharmacy from opening in Dunnington.

Michael Wilson and his seven partners claim their doctors' practice in the market town will be stripped of its own dispensing business, with dire effects on their livelihood.

Their counsel, Michael Supperstone QC, said rural medical practices countrywide relied heavily on profits from dispensing and, if that were taken away, it would be public healthcare which suffered the most.

The grant of preliminary permission to pharmacist Elliot Goran to open a shop in Dunnington was "tantamount to the revocation of the GPs' licence to dispense", he added.

But Cherie Booth – wife of Labour leader Tony Blair – representing Mr Goran, said he should now be allowed to get on with his business "as soon as possible".

The GPs' insistence that Mr Goran's new pharmacy would dramatically affect their income and the viability of their practice should be taken "with a little pinch of salt", she told judge Justice Carnwath.

The court heard that in July, 1995, North Yorkshire Family Health Services Authority granted Mr Goran preliminary consent for the Dunnington shop. He already has one shop in nearby Badger Hill. But Mr Supperstone claimed that the GPs had been denied the right to fully put their objections.

The FHSA had not asked for the GPs' written views on whether a new pharmacy was 'necessary or desirable', nor had they been told the date of the oral hearing.

"It is obvious that the doctors should enjoy the protection of natural justice, which involves them being able to make representations and being able to participate in hearings. By not being present at the hearing, the doctors were not able to answer points made by Mr Goran.

"We say that in no real sense were the doctors invited to participate in the decision-making process, nor did they do so," said Mr Supperstone.

Timothy Dutton, on behalf of the FHSA, said: "The authority has discretion in this case as to how it is to conduct its oral hearings. There is no right for the individual doctors to be present or represented.

"There is, in my submission, no need to imply the right to be present in circumstances where other representative bodies are present, and where any relevant information submitted has been considered."

Justice Carnwath reserved his decision on Monday, after hearing a day of legal argument, saying he would give his ruling "as quickly as possible".

... and dispensing doctors opposed by fighting pharmacy

L Rowland & Co is fighting a decision to allow doctors to dispense in a small Welsh town which already has a pharmacy.

Last autumn, Clwyd Family Health Services Authority granted permission for doctors at Corwen's health centre to dispense for patients living more than a mile away from the local branch of L Rowland & Co. But this could mean the pharmacy being forced to close.

Superintendent pharmacist Neil Ferguson told *C&D* the pharmacy would lose half its dispensing business, as about 55 per cent of patients on the list live over a mile away. The company has asked for an appeal and is waiting to hear from the Welsh Office.

The GP practice has two doctors and wants to increase its income to support a third, but the move has been opposed by the local council because of the effect on the pharmacy.

London LPCs on course to improve team skills

Local pharmaceutical committees in London are to receive training in both teamworking and leadership.

Redbridge & Waltham Forest and Barking & Havering LPC members are being offered a free three-evening training course in leadership and communication, teamwork and motivation, and time management, sponsored by Pharmacia & Upjohn.

Hemant Patel, the secretary of both LPCs, says that while the course will improve LPC knowledge and efficiency, it is also open to 'active contractors' who work with the LPCs.

Pharmacists interested in attending the course should contact their LPC secretary.

Look to a healthy lifestyle

This month's Counterpart module looks at lifestyle and health. It covers basic nutrition and the role of dietary supplements, slimming, control of diet and issues like smoking and exercise.

The Pharmacist's Briefing appears on pp693-694. Counterpart is accredited by the College of Pharmacy Practice. Thanks to the sponsorship of Whitehall Laboratories it is a cost-effective way to ensure your pharmacy assistants comply with the Royal Pharmaceutical Society's training requirements.

Subscribers who wish to enroll staff now, and work through the modules already published, can do so at a subsidised price. Details appear in last week's *C&D* on p660; alternatively, speak to Sue Cheeseman on 01732 364422 ext 2462.

If you are a course user, but have not registered to use the interactive telephone marking system, you need to register now.

● Pharmacist's Briefing (April 20) on Women's Health. The section on the oral treatment of vaginal thrush should have read: "The oral treatment is absorbed within a couple of hours and improvement is usually felt within 24 hours".

Superstores set to open in NI

The supermarket pharmacy-free status of Northern Ireland may be ended when Sainsbury opens its first stores there.

Two stores will be opening in Ballymena and Coleraine before Christmas, and Sainsbury is hoping to include a pharmacy in at least one, subject to the stores being granted licences. It is thought a pharmacy will relocate to the site of a third store, set to open next spring in Newtown Breda, south Belfast.

Northern Ireland does not yet have any of the large supermarkets that are a feature in the rest of the UK. In his address to the Ulster Chemists' Association, Barry Andrews, managing director of Moss Chemists, warned of the problems faced by independents on the mainland (p698).

Tesco says it has no plans to open pharmacies in any of its planned Northern Ireland stores. The first of three is expected to open in the autumn.

Drug misuse action scheme launched

A booklet launched this week gives parents information on how to talk to their children about drug misuse.

The booklet, 'A parents' guide to drugs and solvents', gives information on the drugs likely to be misused, how to tell if children are using them and where to get help.

Published by the Health Education Authority and the National Drugs Helpline, copies are available on the drugs literature line 0800 987999. After June 10, pharmacists will be able to get bulk supplies from Solo Communications on 01304 614731.

The Government is contributing a further £2 million to boost local efforts against drug misuse.

The money will go to a new Challenge Fund, enabling drug action teams to bid for funding for projects that will help tackle drug abuse at a local level. The teams will be encouraged to form partnerships with the private sector.

Over 100 drug action teams have been set up in England to implement the Government's 'Tackling drugs together' strategy launched a year ago. The groups bring together the voluntary sector, police, schools and local education authorities.

● The Welsh Office has launched a package of measures to fight drug and alcohol misuse, particularly in the young. The strategy document, entitled 'Forward Together', also outlines how the treatment and rehabilitation will be provided.

Welsh intervention trial success

A pharmacist prescribing intervention trial is showing significant savings can be made in doctors' drug spending.

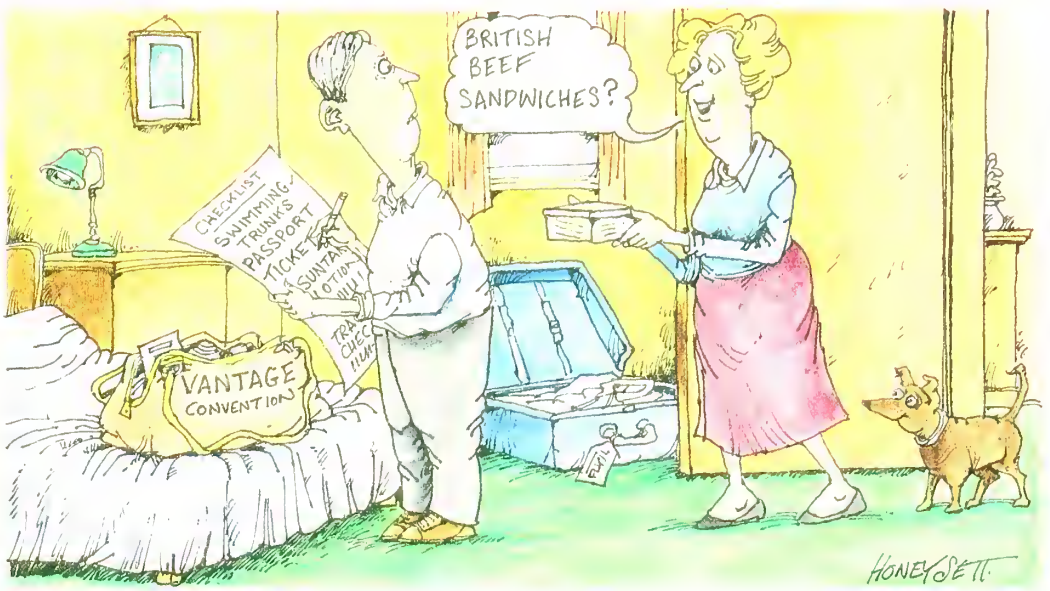
The results indicate annual savings of almost $12,000 can be made by the ten participating pharmacies for the six GP practices in the trial each year.

The three-week trial last autumn in the Upper Rhondda Fawr in Mid-Glamorgan (*C&D* September 16, 1995, p379) saw pharmacists reporting 112 cost-saving interventions to GPs using a signed card system.

GPs agreed with 98 per cent of the recommended interventions, such as generic and continuity prescribing. Maintenance interventions, such as adjusted dose, also contributed to the savings.

All six practices showed a decrease in their projected budget for this fiscal year. The one control practice, where no such interventions were made, showed a significant increase.

Andrew Burr, of the Welsh Prescribing Support Centre, says the data is very interesting. "It shows community pharmacy can have a major impact on prescribing. The data is of key value for negotiations for the Pharmaceutical Services Negotiating Committee."



The Vantage convention is taking place in Madrid this week

WHO sets guidelines for drug donations

The World Health Organisation has issued a set of guidelines for drug donations in emergency and long-term aid programmes to improve the quality of drugs being donated and reduce wastage. Although not promoted as international regulations, the guidelines are intended to serve as a basis for the governments and organisations concerned.

The guidelines are based on the principles that:

- donations must benefit the recipients
- they should support existing government policies and administrative arrangements
- an item whose quality is considered unacceptable in the donor country is unacceptable as a donation
- there should be effective communication between donor and recipient.

Philip Green, secretary and treasurer of the Commonwealth Pharmaceutical Association, which organises the annual collection of old *BNF*s through Pharmaid, welcomes the guidelines.

"The current differing standards in donations and the legal problems of cross border transfer can make [donations] unmanageable and can create more problems than solutions. A worldwide agreed system is very useful," says Mr Green.

London pharmacists paid to advise GPs

Community pharmacists in south London are being paid to tell GPs which patients might benefit from coronary heart disease interventions.

Over 30 pharmacists are being trained to identify patients who might benefit from low-dose aspirin, ACE inhibitors in heart failure, lipid lowering agents or exercise with cardiac rehabilitation after a heart attack. The pharmacists will then send forms to the GPs suggesting, for example, that patients presenting prescriptions for angina treatment might benefit from low-dose aspirin or that people still breathless on high doses of diuretics might improve with ACE inhibitors.

"We're not asking pharmacists to make clinical decisions but to give reminders to GPs," says Ashley Cohen, pharmaceutical adviser to Lambeth, Southwark & Lewisham Health Authority. The patients will not be told about the referrals to avoid damaging confidence in their GPs.

The initiative forms part of a clinical effectiveness project which starts next month. Pharmacists will be paid $50 each to attend meetings with practice nurses and GPs to discuss secondary prevention of heart disease. Each practice will be paid $100 for two members to attend, either two GPs or a GP and a practice nurse. Pharmacists will also be paid for filling in reminder forms. About one-fifth of community pharmacists in the area have expressed interest.

Interdisciplinary approach needed in practice research

Pharmacists need to work with colleagues from other disciplines to ensure practice research of the highest standard, said Professor Nick Barber, as he opened the Health Services Research and Pharmacy Practice Conference 1996 in Manchester last week.

The interdisciplinary theme was maintained throughout the two-day conference with contributions being made by health economists and social scientists as well as pharmacists.

The three main presentations covered:

- initiatives in Australia to measure the influence of community pharmacists on health outcomes
- the contribution which community pharmacy could make in the community care arena
- preliminary data from an oral history of British community pharmacy demonstrating the radical changes in professional practice over the past 80 years.

Over 100 delegates attended and Jane Elliot, from the PPRRC based in Manchester, said the success of the conference demonstrated the need for a forum where research ideas can be discussed in an environment where the emphasis was on methodology as well as results.

Volumes of abstracts from the conference can be obtained from the PPRRC at the University of Manchester by telephoning 0161 275 2342.

Revamped rota still fails to please

A revised 'one in three' rota in the Halifax area has failed to satisfy pharmacists' concerns over a cut in out of hours services.

Pharmacists are still not happy with the compromise of giving a rota service one week in three. It follows an initial rationalisation of the rota service on April 1, which saw some pharmacies increasing their hours while others were removed from the rota list (*C&D* April 20, p517).

Calderdale & Kirklees Health Authority Local Pharmaceutical Committee secretary, Andrew Dobson, says pharmacists are still not happy, but the next review is not expected to be until the start of July.

Pharmacist Peter Marsland of Mytholmroyd, Hebden Bridge who has been taken off the rota list after 35 years, has presented a 500 signature petition to the HA. "Patient power is the only way to change it now," he says.

Report on survey aims to show the Health of the Nation

Over two-thirds of smokers questioned in a recent survey said they would like to give up smoking. People aged 16-24 and 65-74 were least likely to want to quit, while those smoking ten or more a day were more likely than lighter smokers to want to stop.

The survey, 'Health in England 1995' (HMSO, $27.95), found that about 29 per cent of people questioned were smokers, 23 per cent were ex-smokers and 47 per cent had never smoked regularly. Over three-quarters of current smokers had tried to give up.

The report gives the findings of the Health Education Monitoring Survey 1995, which aims to measure progress towards the Health of the Nation White Paper targets.

Nearly a quarter of respondents had been sunburnt in the previous 12 months. Sixty-nine per cent identified all four ways to reduce skin cancer (staying in the shade, using a sunscreen, avoiding the mid-day sun and wearing a wide-brimmed hat). However, nearly two-thirds of women said that having a suntan was important to them.

Thirty per cent of men and 24 per cent of women had changed their sexual behaviour because of concern about AIDS. Only 17 per cent of people thought it would be difficult to raise the subject of using a condom with a new partner and 96 per cent thought using condoms would show responsibility, although only 64 per cent of women and 54 per cent of men said they would use a condom if they had sex with a new partner.

About 43 per cent of men and 36 per cent of women said they sometimes got confused about which foods were supposed to be healthy and which were not, while 70 per cent thought that experts never agree about what foods are good for you.

Nurses set to prescribe more

It is likely that nurses will be allowed to prescribe more medicines on the NHS.

The Department of Health's chief nursing officer, Yvonne Moores, said last week that the expert group which decides on the medicines to be included in the nurses' formulary has been reconvened to consider possible changes.

"Certainly there will be some additions," she told a medical journalists' briefing. "There won't be a sudden doubling [of products], but the formulary will be built up, step by step, in the light of experience."

The final report on the one-year pilot study on nurse prescribing is expected soon. Ms Moores said the experiment had already shown benefits to patients – who had had quicker and easier access to medicines – and to nurses in terms of professional accountability. On cost benefits, the data were "telling us that nurses were very good indeed at thinking carefully about prescribing," she said.

The project was extended for a year from April 1 to 150 trained district nurses and health visitors. Again, there would be much data collection and evaluation, she said: "I must say that I'm very optimistic. It's been a huge responsibility for the nurses involved and they know it."

GPs talk on team tactics

GPs recognise the role of pharmacists in the primary healthcare team, but blame geography on the lack of full integration within that team.

Speaking at a seminar organised by the National Pharmaceutical Association at last week's General Practice Conference, television celebrity and columnist Dr Mark Porter said one of the reasons why pharmacists were not fully integrated members of the primary healthcare team was their geographical distance from the surgeries.

Ways to overcome this geographical barrier were discussed, together with areas where pharmacists can work closely with surgery staff. Lyn Longridge, practice manager of a large fundholding practice in Tewkesbury, believed these areas would include prescription collection and delivery services; PACT analysis; formulary development; home visits and brown bag schemes.

The panel also included two pharmacists who talked about their own experiences of working with their local GP practice. Peter Marshall, deputy chairman of Numark and with a pharmacy in Skipton, said liaison led to significant cost savings, as well as job satisfaction.

● Mr Marshall is not a board member of the NPA, as stated in last week's *C&D*.

Surgichem not involved in MDS fee loss

Surgichem has refuted claims by London pharmacist Atul Kantaria that he lost a fee from residential homes towards the cost of providing the Nomad monitored dosage system as a result of the company's marketing methods.

Surgichem's managing director Norman Niven says: "Surgichem had nothing to do with this. There is no link whatsoever between the activities of our sales team and Mr Kantaria losing his fee."

Mr Kantaria, who runs a business from Chalk Farm Parade, London NW3, serviced three homes owned and run by the Hampstead Old People's Housing Trust. He negotiated a fee when he introduced monitored dosage to the homes.

Surgichem's view is supported by the Central & Cecil Housing Trust, which acquired the homes in April, 1995. Barry Newitt, the regional manager for the new owner, says that on the basis of previous experience C&CHT decided it would not pay for the MDS service.

He met Mr Kantaria, who is still servicing the homes, at the beginning of May to restate the housing association's position. Mr Kantaria, who invoices annually, says he has not been paid since April, 1995.

"While I can understand Mr Kantaria's disappointment, I cannot see how he has got the notion that we were involved in the decision," says Mr Niven. "The market is driven by Boots. What Surgichem is doing is providing independent pharmacists with a means to safeguard their care home business."

Hydrocortone 2mg recall

MSD have recalled selected batches of Hydrocortone 2mg due to unexpectedly low and variable dissolution rates for some tablets. The six batches recalled are: HB31330, HB31340, HB44990 (all 100 tablet packs expiring June 2000); HC04480 (30s exp Oct 1997); HB53440 (30s exp Oct 2000) and HC0447 (30s exp Oct 1997). Pharmacists will receive credit for any returned stock. For further information contact Fiona Draper on 01992 452046.

Renal guidelines

Health authorities have been asked to review services for patients with end stage renal disease. The DoH has issued new guidelines and wants to ensure that there is a comprehensive framework in place for patients.

Assistants' role

Media attention is being drawn to the high level of training of pharmacy assistants by the Royal Pharmaceutical Society. A press release points out that by July of this year, all the 40,000 assistants who regularly sell OTC medicines will have started or completed a training course.

ASA complaint upheld

The Advertising Standards Authority has upheld a complaint against Bioglan Laboratories' advert which highlighted that its bath oils and creams contained no lanolin. The ASA says: "The inclusion of 'no lanolin' in the advert implied the problem [of lanolin hyper-sensitivity] was more widespread and more serious than it was."

Safeway restructures allergy testing

Safeway has restructured its allergy testing service to offer coverage of up to 150 allergens.

The service has been available in around 15 Safeway pharmacies, with testing for ten allergens. Now the company has initiated a revamped pilot service through just five stores in the south east of England.

Allergens which will be picked up include animal dander, pollen, house dust mites and peanuts. The tests will be performed by specially-trained pharmacists or nurses.

Speaking for Safeway, Melissa Crivon says the company will analyse the success of the scheme over the next six months to determine whether it will be rolled out nationally.

INDUSTRY VIEWPOINT

Delivering discipline

Independents suspect that multiples fare much better than they do with major manufacturers. More often than not they're right. The main thing is not to beat the breasts and bemoan the unfairness of it all: there is nothing more likely to create a barrier than this negative approach.

If independents want to participate in the benefits enjoyed by the multiples, they need to recognise why manufacturers favour the multiple and look to ways of trying to level the playing field.

There are two key reasons for a multiple bias. There is the sheer brute buying power and, perhaps more importantly, the discipline offered by multiples gives manufacturers the confidence to know that a negotiated agreement will be delivered by each outlet within the organisation.

There are a number of voluntary trading groups (VTGs) that exist primarily to benefit the independent and are capable of fulfilling the role of interface between manufacturer and a polyglot of independents. If those VTGs are not delivering the benefits sought by the independent, then their members should be asking 'why not?'

The discipline offered by multiples gives manufacturers confidence

The answer is that independents join a VTG not for the overall package offered, but to select individual benefits. Other activities are discarded as not attractive. Without the disciplines inherent in a unified group no manufacturer will feel comfortable in doing deals enjoyed by multiples.

The VTG needs to concentrate on ensuring that its membership has joined for the right reasons and is prepared to fully commit to all activities. If members do not give full commitment, the VTG will be weakened and members will lose potential benefits.

Some sacrifice of independence may well be a good investment in return for income benefits enjoyed by the multiples.

This column is contributed by a senior industry manager.

Topical Reflections

Fight from within ...

I have always respected the Young Pharmacists' Group for its obvious dedication and professionalism, but, as I said some four years ago, I also consider its unofficial hustings for Council elections to be ill-considered. This year, the candidates voted with their feet and the hustings were cancelled. They obviously believe that this event is now an irrelevance. This gives me no satisfaction because, by ignoring the opinions of young pharmacists, we all run the risk of marginalising what should be the most enthusiastic and innovative section of the profession.

The present branch system is the cornerstone of our democratic process, but its promotion as the envy of many other professions cannot hide the apathy that afflicts the majority of its members. I have once again recently witnessed the regular apology for an annual general meeting in my local branch where new faces were prominent by their absence and clique politics ensured the same tired faces once again controlled our local destiny.

But where were all those young pharmacists yearning for change? In the main, conspicuous by their absence.

The YPG hustings are an example of applying external pressure without assuming responsibility. Young pharmacists should demonstrate their commitment by becoming active within the branches and not by barracking from outside. They should lead by example, become elected to local committee, become known within local politics and then actively campaign for election to Council. Then they will have the opportunity to criticise and then the authority to change.

In favour of this niche

I am not normally in favour of niche marketing of branded versions of the same drug for different purposes, but in the case of Canesten there is an overwhelming logic to the launch of new Canesten AF cream, announced this week (**Counterpoints** May 11).

Bayer has consistently supported pharmacy sales of Canesten by rejecting large bonus deals on an artificially low baseline price in favour of a high basic profit on return. This has resulted in Canesten being a long-standing brand leader in my pharmacy, fuelled by my preferential recommendation of its use to customers. However, if I have ever had a criticism it was that the use of the 1 per cent cream for athlete's foot seemed contrary to its more well known promotion as a treatment of vaginal thrush.

The specific Canesten AF is a welcome addition to the range and if it remains as a Pharmacy only distributed product, with the promise of more to come and the retention of the existing high returns, I will enthusiastically support its sale.

Pre-payment made easy

The issue of pharmacies selling pre-payment certificates is set to become a national issue, with the announcement on April 30 by the minister of health that he intends making the practice legal within the regulations. Steven Axon, secretary of the Pharmaceutical Services Negotiating Committee, has said that PSNC is in favour of this change, as long as pharmacists are not out of pocket. I would go further and say that I will not co-operate unless I am paid a real fee for the service.

If properly remunerated, pharmacists could provide an efficient service, which can then be centrally controlled by, for example, the Prescription Pricing Authority, with regular submissions being made via the monthly prescription bundle. At present, the scheme is locally administered by individual health authorities, but by using 10,000-plus pharmacies submitting to a central registry, large resources from HA duplication would be released and this money could be used to fund the scheme.

However, I would like to go further and suggest that at the same time an instalment payment system similar to that which I suggested on April 13 could be introduced, but perhaps this would be one step too far. I cannot see the Government embracing a scheme which, while helping those in need, deprived the Treasury of some of its ill-gotten prescription tax gains!

SCRIPTspecials

Skelid – a new bisphosphonate

Skelid is a new oral bisphosphonate licensed for the treatment of Paget's disease of the bone.

Skelid (28 tablets, NHS price £99) contains tiludronic acid 200mg as disodium salt 240mg. The adult treatment is two tablets (400mg) to be taken as a single daily dose for a course of three months. Tiludronic acid works by inhibiting the bone resorbing activity of osteoclasts.

Most patients respond to treatment within this period and improvements of serum alkaline phosphotase levels may last up to 18 months after discontinuation. Tiludronic acid is not recommended for children.

The course can be repeated if biochemical markers (increase in serum alkaline phosphotase with or without an increase in hydroxyprolinuria) or pain suggests a relapse, but only after an interval of at least six months.

Skelid is contra-indicated in patients with a history of allergy to bisphosphonates; severe renal failure; juvenile Paget's disease; and in pregnancy and lactation.

Side-effects are mainly gastro-intestinal and incidence is dose-related. In rare cases, asthenia, dizziness, headache and skin reactions have been reported.

Patients should avoid food two hours before and after taking the dose, particularly foods rich in calcium. Gastro-intestinal topical treatments, antacids and indomethacin should also be avoided within two hours of taking tiludronic acid. Aspirin, diclofenac and digoxin do not significantly affect tiludronate pharmacokinetics. Products likely to cause mineralisation disorders should be avoided.

Sanofi Winthrop Ltd. Tel: 01483 505515.

Sotacor indications

Sotacor (sotalol hydrochloride) is now indicated only for the treatment/prophylaxis of ventricular and supraventricular arrhythmias. It should no longer be used for angina, hypertension, thyrotoxicosis, or for secondary prevention following myocardial infarction unless one of these cardiac arrhythmias is present.

Bristol-Myers Squibb Pharmaceuticals Ltd. Tel: 0181 572 7422.

Saliveze

Saliveze, a new artificial saliva mouth spray, is a colourless, aqueous solution with a neutral pH and a mild mint flavour. The electrolyte concentrations are similar to that found in normal human saliva. Carboxymethylcellulose is included to provide viscosity. It is indicated for use in patients suffering dry mouth from radiotherapy or sicca syndrome. Saliveze is on the ACBS list (50ml bottles, retail price £6.16).

Wyvern Medical Ltd. Tel: 01531 631105.

Accupro 40mg

New supplies of Accupro 40mg in calendar packs of 28 tablets are now available and will be used to fill all future orders (basic NHS price £9.75). Stocks of the 56-pack are exhausted

Parke-Davis. Tel: 01703 620500.

Klaricid 500mg

Abbott is introducing a new calendar pack of Klaricid (clarithromycin) 500mg (ten x 14 tablets, basic NHS price £224.90).

Abbott Laboratories Ltd. Tel: 01628 773355.

Calcichew launched with vitamin D3

Calcichew-D3 Forte is a combined calcium and vitamin D3 chewable tablet now available from Shire Pharmaceuticals.

Each tablet contains calcium carbonate 1,250mg (equivalent to 500mg of elemental calcium) and cholecalciferol 400iu (equivalent to 10mcg vitamin D3). Vitamin D is considered to be essential for the regulation of calcium and phosphate homeostasis, and bone mineralisation.

Calcichew-D3 Forte is indicated for the treatment and prevention of vitamin D/calcium deficiency, particularly in housebound elderly patients. It can also be used as an adjunct to specific therapy for osteoporosis in cases where therapeutic supplementation is needed.

The adult dose is two tablets daily, preferably one in the morning and one in the evening. It should not be given to children under 12 years.

The product is contra-indicated in hypercalcaemia, severe hypercalciuria, osteoporosis due to prolonged immobilisation, milk-alkali syndrome and severe renal failure. People with mild to moderate renal failure or mild hypercalciuria should have periodic checks of urinary calcium excretion and plasma calcium.

At least three hours should pass between taking Calcichew-D3 Forte and tetracycline, fluoride or iron to prevent absorption impairment. Thiazide diuretics reduce urinary calcium excretion and may increase the risk of hypercalcaemia. This should be noted in patients on digoxin.

Calcichew-D3 Forte has a P licence (100 tablets, £16.50).

Shire Pharmaceuticals Ltd. Tel: 01264 333455.

Spacehaler knocks miles off drug delivery

Evans Medical is introducing Spacehaler, Europe's first vortex metered dose inhaler, which is said to reduce the delivery speed of the aerosol dose by 66mph compared to a standard MDI, and offers some of the benefits of a large volume spacer.

The dose leaves the Spacehaler as a slow-moving cloud travelling at 4mph, which should be more comfortable for patients than the 70mph jet released from conventional MDIs. The fast jet hitting the throat can cause the patient to gag or stop inhaling.

The cloud from the Spacehaler allows most of the non-respirable fraction of each dose (72-86 per cent) to be retained in the inhaler and not be deposited in the mouth or throat. It produces lung deposition at least as good as the standard MDI, but from a reduced total steroid dose. The Spacehaler resembles a conventional MDI in size and shape.

Spacehaler is available as beclomethasone dipropionate in three strengths: 50mcg (£5.43 basic NHS); 100mcg (£10.32); and 250mcg (£23.10); and salbutamol (£5.43). All devices are labelled and embossed in established colours to help patient recognition.

Evans Medical Ltd. Tel: 01372 364034.

Rotacaps

Ventolin, Becotide and Ventide Rotacaps are moving from a pack size of 100 to a patient pack of 112. Under current arrangements pharmacists are required to dispense the exact number of Rotacaps prescribed. The PSNC says the DoH has agreed that, when 100 Rotacaps are prescribed, 112 may be dispensed provided the prior approval of the prescriber is obtained. To ensure correct payment, the FP10 form must be endorsed 'PA (prescriber approved) 112 disp'. This applies only in situations where 100 Rotacaps have been ordered.

PSNC. Tel: 01296 432823.

Product transfers

The following products have been transferred from Lilly Industries to King Pharmaceuticals: Nebcin vials 20mg/2ml, 40mg/1ml, 80mg/2ml; Allegron tablets 10mg x 100, 25mg x 100; Capastat 1g vial; and Cycloserine 250mg x 100 capsules. The distributor is Distriphar UK and all future orders and delivery enquiries should be addressed to:

Distriphar UK. Tel: 01895 837779.

Hormonin packs

Hormonin is now available in a new patient pack consisting of a three-month supply of 90 tablets (£6.44 basic NHS). The new pack replaces the 100-tablet pack.

Shire Pharmaceuticals Ltd. Tel: 01264 333455.

Improved taste

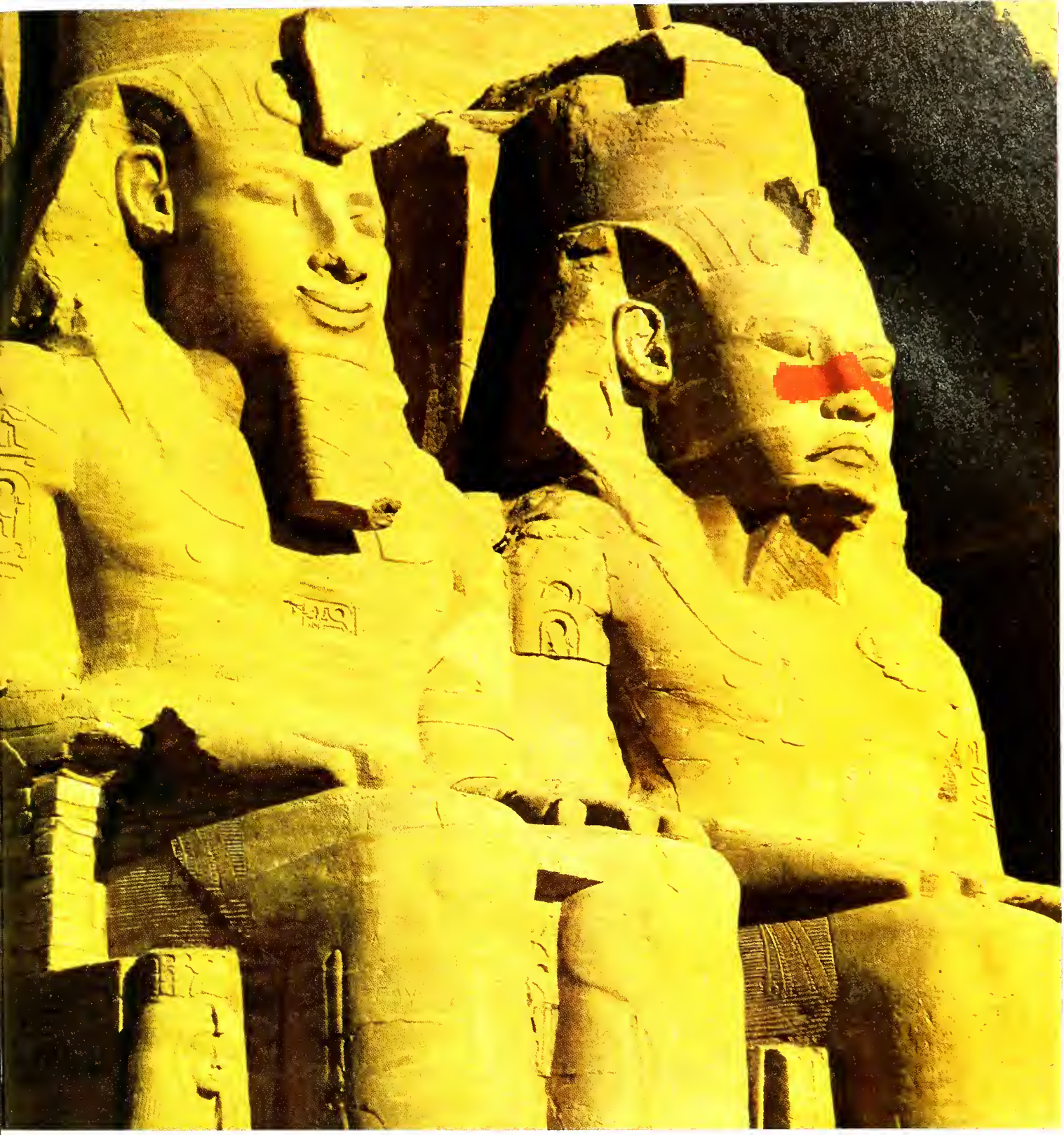
Nutricia Clinical Care has improved its high-energy supplements, Fortisip and Fortijuice, with reformulations and more flavours. Fortisip is now available in Toffee and Chicken. The protein content of Fortijuice has been increased to 8g/200ml.

Cow & Gate Nutricia Ltd. Tel: 01225 768381.

3M's new spacer

3M Health Care is the new UK distributor for the Aerochamber device range, which consists of four holding chambers: standard Aerochamber device (blue), £8; standard device with mask, £16; child Aerochamber (yellow) with mask, £14.36; and infant Aerochamber (orange) with mask, £14.36 (all prices excluding VAT). They are designed to be used with MDIs to improve drug deposition and aid compliance.

3M Health Care. Tel: 01509 611611.



NUROFEN
COLD & FLU
ibuprofen
pseudoephedrine

TAKES CONTROL OF INFLAMED SUMMER SINUSES

When summer's here the last thing your customers want is the misery of runny noses, stuffy colds and inflamed sinuses.

Nurofen Cold & Flu gives your customers symptomatic relief with the powerful reassurance of the Nurofen name. By reducing sinus inflammation and providing effective decongestant action, there's no more effective way to take control of inflamed summer sinuses.

Recommend Nurofen Cold & Flu, and you'll find it's not only your customers who are having the best summer in years.

PRODUCT INFORMATION: Nurofen Cold & Flu: each tablet contains 200mg Ibuprofen BP and 30mg Pseudoephedrine Hydrochloride **Indications.** Effective in the relief of symptoms of colds and flu with congestion, such as aches and pains, headache and feverishness, sore throats, sinusitis and blocked noses **Dosage and Administration.** Adults and children over 12 years Initial dose 2 tablets taken with water, then if necessary 1 or 2 tablets every 4 hours. Do not exceed 6 tablets in any 24 hours. **Precautions and Warnings.** Nurofen Cold & Flu should be avoided by patients with a stomach ulcer or other stomach disorder Asthmatics, anyone allergic to aspirin and [illegible] regular medication and pregnant women should be advised to consult their doctor before taking [illegible] Cold & Flu Not recommended for children under 12 If symptoms persist for more than [illegible] days patients should consult their doctor **Product Licence Number.** Nurofen Cold & Flu 0327/[illegible] **Licence Holder.** Crookes Healthcare Limited, Nottingham, NG2 3AA **Legal Category.** [illegible] **Price:** £[illegible] for 12 £3.79 for 24, £4.99 for 36 Prices correct at the time of going to press. Date of preparation Apr 1996

CROOKES HEALTHCARE

COUNTERpoints

Cool campaign for Driclor

Stiefel Laboratories has launched a new support campaign for Driclor Solution – its OTC version of Driclor for excessive perspiration.

The press campaign aims to increase public awareness about the medical condition hyperhidrosis and its treatment. 'Stay cool' giveaway promotions will appear in summer issues of women's interest consumer magazines.

A radio commercial for Driclor Solution will start in June.

An extensive range of display material for pharmacies includes a small counter display unit, A2 window display card and shelf edger.

Stiefel Laboratories (UK) Ltd. Tel: 01628 524966.

Clearer labels for Potter's herbals

Potter's has introduced a new look for its licensed herbal remedies. Labels provide more information on ingredients, dosages and treatment.

The packaging is designed to give the brand more shelf impact and to encourage block merchandising.

Tony Hampson, Potter's managing director, comments: "The new look will enable us to compete more effectively for shelf space alongside conventional drugs."

Potter's Herbal Medicines. Tel: 01942 234761.

Cow & Gate expands into vitamin sector

Cow & Gate is expanding its non-food portfolio with the launch of Folicacid – a single vitamin supplement (400mcg) for women who are planning to conceive and for those in the early stages of pregnancy.

The new supplement comes in small, orange-flavoured, chewable tablets. Packaging is in an eight-week calendar pack ($3.95) designed to ensure the one a day dosage is easily followed.

Cow & Gate is backing the launch with a $250,000 support programme. Press advertising in women's interest and parenting titles will appear in July and October. A major direct mail programme to newly-pregnant women is being implemented and leaflets will be distributed through GP surgeries.

Point of sale material includes 'bus stops' which draw attention to the product on-shelf.

- Cow & Gate estimates that the folic acid market is currently worth around $2 million. However, the company predicts that this will grow to $10m in the next five years.

The launch of Cow & Gate Folicacid follows recommendations from the Department of Health about the importance of folic acid in the diets of women planning a pregnancy and pregnant women.

Research has shown that folic acid, taken prior to conception and during the first 12 weeks of pregnancy, can reduce the incidence of neural tube defects, such as spina bifida, anencephaly and encephalocoele, in infants.

The Health Education Authority is currently running a folic acid awareness campaign, which will continue for the next two years.

- Cow & Gate Folicacid is the second non-food introduction by the company following last summer's launch of breast pads.

Cow & Gate Nutricia Ltd. Tel: 01225 768381.

Unichem service for disabled customers

Pharmacy customers in need of products for rehabilitation and independence at home can now benefit from a new Unichem service – Home Solutions.

To enhance the launch, 200 top lines will be offered by Smith & Nephew exclusively to Unichem pharmacists until the autumn.

The service features 1,400 items – ranging from adjustable beds to kitchen accessories.

Products are available for order via Prosper and delivery is expected to take just five working days.

Special starter packs containing catalogues, price lists and order forms are available for pharmacist customers.

Unichem plc. Tel: 0181 391 2323.

Sporting chance for Daktarin

Sales of the Daktarin anti-fungal range are being boosted with a $500,000 advertising spend until August.

The advertisements highlight the efficacy of the range in treating and preventing the problem of athlete's foot.

The campaign is running in the national press to coincide with key sporting events – including football's FA Cup and the European Championships, the Stella Artois and Wimbledon tennis championships, and the cricket test matches.

In-pharmacy support includes point of sale material and educational consumer literature.

J&J MSD Consumer Pharmaceuticals. Tel: 01494 450778.

Gold award goes to Unipath

Unipath has received a gold award for its education programme for pharmacy assistants in the annual ISP Awards.

The company makes Clearblue One Step, Clearplan One Step and Clearview HCG.

The programme ran in Unipath's 'Talking Point' magazine.

Unipath Ltd. Tel: 01234 347161.

TV revitalises Andrews

Andrews Salts is on TV for the first time in over 20 years. Smithkline Beecham is spending $2.5 million on advertising for the relaunched brand, which will run until August.

Humorous TV commercials are on air for both Andrews Salts and Antacids. A rally car featuring people eating on the move supports Andrews Antacid, while a Mexican cantina theme is being used to highlight Andrews Salts.

Both advertisements are designed to clearly show the causes of stomach problems without focusing on the pain of suffering.

The Andrews packaging has been redesigned to emphasise the revitalising effect of the brand. Special packs and new point of sale material are available.

Smithkline Beecham Consumer Healthcare. Tel: 0181 560 5151.

All you need to stock to get rid of thrush.

Stock up now for the massive £2 Million TV and women's press campaign

Relieves itch immediately. Itch is the most common symptom of vaginal thrush and an itch needs immediate relief. New Canesten Combi contains a handy tube of 1% clotrimazole cream for immediate soothing relief.

Treats infection fast. And a single dose pessary to be used at a convenient time to clear the infection fast. With massive support and Canesten's unrivalled position as market leader the only interactions you're likely to see will be with new customers.

Relieves itch immediately • Treats infection fast

Abridged Prescribing Information. Presentation: One Canesten 1 Pessary (containing 500 mg Clotrimazole BP) plus a 20 g tube of Canesten 1% cream (containing 1.0% Clotrimazole BP). **Uses** Pessary for candidal vaginitis and associated vulvitis and to treat the sexual partner to prevent reinfection. **Dosage and Administration:** *Adults* The pessary should be inserted intravaginally, preferably at night, using the applicator provided. The cream should be applied night and morning to the vulva and surrounding area and/ or to the partners penis to prevent reinfection. *Children* Paediatric usage is not recommended. **Contra-indications:** Hypersensitivity to clotrimazole. **Warnings and Precautions:** Medical advice should be sought if this is the first time the patient has experienced symptoms of candidal vaginitis. Before use, medical advice must be sought if any of the following are applicable: More than two episodes of candidal vaginitis in the last six months; previous history of a sexually transmitted disease or exposure to partner with sexually transmitted disease, pregnancy or suspected pregnancy, aged under 16 or over 60 years, hypersensitivity to imidazoles or other vaginal anti-fungal products. Do not use if the patient has any of the following symptoms, whereupon medical advice should be sought: Irregular vaginal bleeding, abnormal vaginal discharge, blood-stained discharge; vulval or vaginal ulcers, blisters or sores; lower abdominal pain or dysuria, any adverse events such as redness, irritation or swelling associated with the treatment, fever or chills, nausea or vomiting, abnormal, foul smelling vaginal discharge. If no improvement in symptoms is seen after seven days, the patient should consult their doctor. **Side-effects** Rarely local mild burning or irritation immediately after use. Hypersensitivity reactions may occur. **Use in Pregnancy:** Only when considered necessary by the clinician. If used during pregnancy, extra care should be taken when using the applicator to prevent the possibility of mechanical trauma. **Legal Category** P. **Package Quantities and Basic NHS Cost:** 1 x 500 mg pessary packed in foil, plus a 20 g tube of Canesten 1% cream. An applicator for the pessary is included. £4.25. **Product Licence Numbers** Cream 10010/0016P, 500 mg Pessary 0010/0083. **Further information available from:** Bayer plc, Pharmaceutical Division, Bayer House, Strawberry Hill, Newbury, Berkshire RG14 1JA. Telephone (01635) 563000. **Date of Preparation:** July 1995. © Bayer plc January 1996

Facelift for SB's Oxy Cleanser

Smithkline Beecham is relaunching its Oxy Daily Cleanser with a larger size and new packaging.

The pack has been increased in size from 100ml to 150ml at no extra cost (£3.19) to provide better value for money. The carton has been removed to encourage trial among Oxy's teenage audience.

Press advertising to support Oxy Daily Cleanser will run in a series of teen titles from June.

Smithkline Beecham Consumer Healthcare. Tel: 0181 560 5151.

Compeed gets plastered

Coloplast has introduced the Compeed Hydro Cure System, a range of plasters using up to date hydrocolloid technology.

The system relies on creating the moist conditions needed to encourage rapid healing. Unlike a conventional plaster, which is made of gauze, Compeed has a hypo-allergenic polyurethane adhesive backing, which absorbs the skin's own natural moisture, forming a protective moist cushion to relieve pain and encourage cell growth.

The plasters are slim, light, waterproof and blend with the skin.

The range comprises five new lines: Compeed Cuts and Grazes (ten medium or six large plasters, retailing at $2.59); Blisters (six small and five medium, $3.49); Corns (ten, $2.69); Heel Cracks (two, $3.49); and Callouses (six, $3.49).

There is a Freefone helpline (0800 592938) answering trade and customer enquiries about the new plasters.

Coloplast Ltd. Tel: 01733 392000.

Hayfever help

A Hayfever Hotline has been set up by Ciba Vision Ophthalmics – maker of Otrivine Antistin. Callers can listen to information about hayfever and request a free 'Pollen Protection Plan' on 01489 775522.

Ciba Vision Ophthalmics. Tel: 01489 775504.

VMS campaign

Seven Seas is funding a national education campaign on the health and beauty benefits of gamma linolenic acid (GLA) supplementation. Spearheaded by the GLA Information Office, the campaign incorporates a telephone helpline, free educational literature, press briefings and newsletters.

Seven Seas Health Care Ltd. Tel: 01482 375234.

Summer boost for Sanatogen

Sanatogen one a day vitamin supplements are being boosted with a lively new advertising campaign this summer.

Advertisements for Sanatogen Vegetarian, Sanatogen Pronatal and Sanatogen Super Cod Liver Oil supplements are in women's magazines until July.

Part of a $5 million promotional spend for 1996, the campaign features 'Eat your greens', 'baby food' and 'cod's wollop' messages.

Roche Consumer Health. Tel: 01707 366000.

Bathtime fun from Prelude

Newest addition to the Prelude Collection is Bump in the Night Collectables Bath and Shower gel.

Aimed at 6-11-year-olds, 'Bump in the Night' is a new BBC series set to run on Saturday mornings later this year. Creatures from this series (Molly Coddle, Mr Bumpy and Squishington) are featured on the three new bath and shower gels ($3.99).

Prelude UK Ltd. Tel: 0191 233 0293.

Health advice

Reckitt & Colman will be giving health advice at a series of Baby & Toddler Shows. The company's OTC brands Disprol, Bonjela, Dettol, Gaviscon and Fybogel products will all come under scrutiny from the general public. The shows will be at Wembley from May 31-June 2, and December 6-8, and at Birmingham NEC from August 30-September 1.

Reckitt & Colman Products. Tel: 01482 326151.

Tea tree oil for healthy feet

New in the UK are two foot care products from Australian tea tree oil producer Thursday Plantation.

Tea Tree Foot Powder ($4.95, 100g) is an extra-absorbent, deodorising powder.

Tea Tree Foot Spray ($3.45, 50ml) is refreshing, cooling and deodorising.

Tea tree oil is a natural antiseptic which also has fungicidal properties. A clinical investigation has demonstrated tea tree oil's effectiveness, says the company.

Health Imports Ltd. Tel: 01274 488511.

Aller-eze takes another bite at sales

Aller-eze Original Formula is the new name for Aller-eze – the antihistamine containing clemastine from Intercare Products.

The pack also has a new look to mark the brand's repositioning as the antihistamine tablet for bites, stings and skin allergies.

The product retains its indication for hayfever, which is clearly depicted on the new packs.

Andy Brough, Aller-eze marketing manager, explains: "Our aim is to drive customers to seek treatment from the pharmacy – expanding the antihistamines sector for pharmacists.

● Research has shown that the UK has three million skin allergy sufferers. Of these, almost one in five do not treat.

Intercare Products Ltd. Tel: 01734 790345.

Impulse goes on display

Elida Fabergé has introduced new point of sale material for Impulse to support independent retailers.

The new promotional material comprises a complete merchandising unit, individual tester units, shelf reservers and a window display unit. It will enable retailers with limited space to differentiate between deodorant and body spray merchandising.

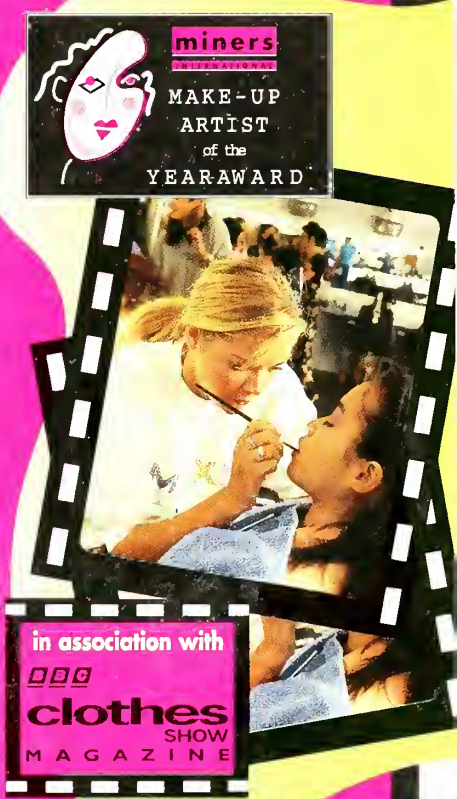
Elida Fabergé. Tel: 0181 481 6000.

Absolutely Fabulous!

Miners cosmetics the original "good time" brand is back better and bolder than ever.

FREE fully illuminated floor stand

New packaging, latest colours, free merchandising units and INDUSTRY BEST MARGINS make Miners a "must have" product.



Miners International in association with the BBC Clothes Show Magazine sponsor a yearly search for THE MAKE UP ARTIST OF THE YEAR, this will be supported by ongoing T.V., magazine and press coverage worth millions of pounds ...make sure you get your share of the action!

No minimum order value equals best available stock turnaround equals most exciting opportunity in cosmetics today. Exclusively distributed by PAUL MURRAY PLC as part of their overall range of profitable products.

Best packaging - latest colours

miners

...yes I want a rep to call

Name ..... Address .....

.....

.....

Post code ..... Tel no .....

return to PAUL MURRAY PLC, School Lane, Chandlers Ford, Hampshire SO53 4YN

Tel: 01703 268444 Fax: 01703 261946

Huggies are high and dry

Kimberly-Clark has relaunched Huggies Pull-Ups practice pants for toddlers.

These absorbent pants are now thinner, with appealing characters on both the front and back. Designed to look like real pants, Huggies Pull-Ups ($4.99 per pack) allow children to feel more grown up as they practice using the potty.

The relaunch is being backed by a new TV and press advertising campaign this summer, with a total marketing spend of $3.9 million.

Together with its sister product, Dry Nites, Huggies Pull-Ups has a 74 per cent share of the UK absorbent pants market (IRI Infoscan, March, 1996).

● Approximately 750,000 children start toilet training every year and toddlers can take up to 12 months to master the use of the potty.

Kimberly-Clark Ltd. Tel: 01622 616000.

Child's play

A new range of brightly-coloured training cups for young children has been launched by NUK.

Made of polypropylene, they have two angled handles with finger grips to make them easy for young hands to hold. The lid is removable, so that it can convert into an ordinary cup which the child can use when it is older.

The NUK training cups come in a choice of colours, including blue, turquoise, jade green and orange. Available in boxes of five, they retail at $2.99 each.

Quest Consumer Products Ltd. Tel: 0181 531 7241.

Conditioning Mud offer

Finders Dead Sea Magik Conditioning Scalp Mud is now twice the previous size – retailing at £5.95 for 150ml. As an added bonus, Finders is giving retailers one 75ml tube free for every order of six 150ml products while stocks last.

Finders International Ltd. Tel: 01580 211055.

ON TV NEXT WEEK

Bazuka: C, CAR

Beconase Hayfever: ITV, C4, C, A, HTV

Bisodol: B, G, Y, C, M, TT, C4

Centrum: C4

Colgate-Palmolive Soft & Gentle: All areas

Gentle Touch: All areas

Ibuleve: C4

Imodium: All areas, except CTV, GMTV, TSW

Nizoral: Sat

Otex: C4

Relaxyl: G

Sensodyne toothpaste: All areas

The Wrigley Company, Sugar Free brands: All areas

Toepedo: B, G, Y, C, TT

GTV Grampian, **B** Border, **BSkyB** British Sky Broadcasting, **C** Central, **CTV** Channel Islands, **LWT** London Weekend, **C4** Channel 4, **U** Ulster, **G** Granada, **A** Anglia, **CAR** Carlton, GMTV Breakfast Television, **STV** Scotland (central), **Y** Yorkshire, **HTV** Wales & West, **M** Meridian, **TT** Tyne Tees, **W** Westcountry

CORSODYL
MOUTHWASH

MINT

GINGIVITIS
TREATMENT

Contains 0.2% w/v chlorhexidine gluconate

600 ml

Now you can give gingivitis the full treatment.

The most powerful OTC treatment for gingivitis is one month's supply of Corsodyl Mouthwash, the equivalent of 2 x 300 ml bottles. Unfortunately most customers only only ask their pharmacist for one bottle instead of two. The introduction of our new 600 ml bottle means you can make sure your customers receive the full course of treatment.

The new 600 ml Corsodyl Mint Mouthwash joins the already best-selling range of Corsodyl Mouthwashes in pharmacies*. The Corsodyl range also includes a Dental Gel and Spray, also useful in the promotion of gingival healing after oral surgery and in the management of recurrent oral ulceration, denture stomatitis and oral thrush.

Extensive clinical trials and over twenty years of unrivalled professional endorsement prove Corsodyl's efficacy.

Corsodyl – The gold standard.

CORSODYL
chlorhexidine gluconate

odyl. Uses. Presentation. inistration. Dosage & Contraindications. Precautions. Side effects. bers and Basic NHS Cost. Corsodyl Spray. Corsodyl Mouthwash. Overdosage. Corsodyl Mint Mouthwash. odyl. Legal Category P. Licence Holder.

Corsodyl is a trademark SB SmithKline Beecham Product Licence

Whose fault is it anyway?

If you sell a product that doesn't live up to its claims, is the onus on you or the manufacturer to do something about it? And what are the risks of you being taken to court? *C&D* reports

We may bemoan the retail dominance of the supermarkets and the High Street chemist chains, but when it comes to customer complaints, they are a hard act to follow.

Not many independent retailers could afford to match the level of service and willingness to appease a customer of, say, Sainsbury. The company's size enables it to offer service beyond the capabilities of most independents. Take, for example, this story recently quoted in *The Guardian*: "At 10.00pm on Christmas Eve, 1994, a Sainsbury's customer in Manchester unwrapped his turkey and smelled something funny. He phoned head office in London, where (though he did not know it) a few birds had been set aside 'just in case'. A turkey was delivered by courier that night, at a cost of £500!" Phew!

So what does all this mean to Mr Whitecoat?

Well, first thoughts that the onus for any faulty product sold in a pharmacy should be relayed to the manufacturer of said 'faulty item' is mistaken. In legislation, you – the retailer – are responsible under the Sale and Supply of Goods Act 1994.

This is an update on the 1979 Act. A key part of the new law is the requirement that the goods must be of 'satisfactory quality'. This replaces the less easily defined 'merchantable quality' of the 1979 Act. 'Satisfactory' means goods have to be durable, safe and free from minor defects.

With regard to the involvement of the manufacturer of said product, shoppers are also protected by the Consumer Protection Act 1987. Here, the consumer can claim against the manufacturer if the product turns out to be defective and causes personal injury or damage of more than £275 to property.

Product claims

Last year, Lloyds Chemists got into hot water over a sun tan cream which claimed a sun protection factor of 15, but when tested was found to be only SPF 12. The case received a lot of publicity as a child had burnt quite badly after using the cream.

However, as Michael Ward, Lloyds' group managing director, points out, the prosecution was taken out by Trading Standards over the fact that the product and the claim did not match up. The matter of the burnt child is still in dispute. Lloyds does not dispute that the cream had the wrong SPF (the case went to court and Lloyds was forced to pay a £3,000 fine), but it does question whether the severity of the burning was totally the fault of the cream.

Tests on the child have shown that burning was worse where the product was ap-plied, indicating that the child suffered a personal skin reaction to the sun's rays (for which the cream cannot be held totally responsible). This claim against Lloyds' insurers is currently ongoing.

So how do manufacturers protect themselves and their retailers from cases of product liability. Stewart Chambers, managing director of Miners International, believes strongly that when it comes to sun care products, full scientific data on the safety of the product must be to hand. Miners commissioned one of the UK's largest independent research companies which carried out comprehensive tests on validating the SPF ratings and general safety of its sun care range, Delph.

> **Sun tan products are becoming almost semi-medicinal in the public mind...**

"As sun tan products are now becoming almost semi-medicinal in the public mind, it was important for us to back our low prices with tangible evidence of product performance. With recent high-profile events in mind, our mainly pharmacy-based customers should expect nothing less from us or any other reputable supplier."

According to the National Pharmaceutical Association, for most pharmacists the problems of product liability are minimal. Glyn Walduck, legal adviser at the NPA, says the claims that he comes across are mostly related to dispensing errors and retailing of out of date products. Mr Walduck also notes that a pharmacist making up nostrums is liable for what he produces and for the ingredients he uses. But, he admits, this practice is becoming increasingly rare.

Know thy supplier

The key to the whole dilemma of product liability is remembering the golden rule: know thy supplier. As the NPA's Mr Walduck says: "Providing you buy from reputable sources and know their identity, then you shouldn't have a problem."

The recent series of Royal Pharmaceutical Society Statutory Committee hearings concerning the activities of an unlicensed wholesaler is a word to the wise in this regard.

Nearly 100 pharmacies have been investigated about dealings in parallel imports with Pierre Schaffer of Margate, Kent, and a total of nine pharmacists have been struck off so far. All had been found to have handled unlicensed products, imported from such faraway places as Mexico. And there had been few checks on Mr Schaffer's *bona fides*.

PHARMACY update

Palliative practice

In a two-part special, Mary Allen, a founder of the Hospice Pharmacists Association and member of the Royal Pharmaceutical Society's working party on palliative care, examines the practical and therapeutic aspects facing this branch of healthcare. This article investigates the practice challenges

The quality of care provided for people who are dying must be of the highest standards. This is more important than in any other area of care because there is no second chance to get it right.

Palliative care is given when illnesses no longer respond to curative treatment, where the goal must be the best quality of life for both patients and their families. It includes the control of pain and other distressing symptoms, and integrates this with a psychological and spiritual approach, so teamwork is essential.

Every community pharmacist comes into contact with people who are terminally ill or with their carers. There can be no pharmacist who does not from time to time dispense, for example, oral morphine in increasing strengths. How do you respond? Do you see your role as complete once the medicines are dispensed?

Or do you stop for a minute and think of what is going on for the patient and his family, and what their needs are? Do you keep an eye on the carers who may be into the grieving process even before their loved one dies? They are very vulnerable at this time and you can help by identifying those who may need treatment for depression and make sure the GP is aware.

Educational resources

- 'Palliative Care', a distance learning course available from the CPPE (0161 237 2058).
- *A-Z Pocket Book of Symptom Control*, Peter Kaye, EPL Publications (ISBN 0-95 19895-1-0).
- *A Guide to Symptom Relief in Advanced Cancer*, 3rd edition, Regnard & Temple. Available from Haigh & Hochland (0161 929 0190).
- *The British National Formulary*: guidance on prescribing in terminal care.
- 'Guidelines for Managing Cancer Pain in Adults', National Council for Hospice and Palliative Care Services. Cost £1. (0171 611 1153).
- *Terminal Care in the Community*, B Stewart, Radcliffe Medical Press (01903 744345).
- 'Care of the Dying', produced by Merseyside Drug Information Services and Fazackerly Hospital. Under revision and will be available shortly. Contact: Jackie Williams (0151 529 3208).

Great progress has been made in palliative care over the last 30 years, due to the efforts of the hospice movement, which started in 1967 with the founding of St Christopher's Hospice in London. Today there are just over 200 hospices in the UK, funded mainly by voluntary donations, with contributions from health authorities.

Team approach

Hospice care is characterised by a team approach to meet the needs of the patients and families, and treatment is free to the patient. Voluntary hospices thrive in being part of the community and each year rely on the efforts of their local communities in generating around £50 million from fund-raising ventures.

Although associated with cancer, some hospices now provide care and support for patients with AIDS, motor neurone disease and other similar illnesses.

Palliative care is provided in a variety of settings – at home, in the hospice, in nursing homes and in hospitals.

There is a great need for further development of care for the terminally ill within the domiciliary setting and pharmacists should ensure that they contribute to the multi-disciplinary team approach that is needed.

However, there is an uneven distribution of specialist palliative support around the country. While some hospitals have palliative care units and the number of special home care teams to provide domiciliary care is increasing, as yet, the integration of pharmaceutical care isn't happening as much as it should, either between pharmacists at the primary/secondary care interface or within domiciliary palliative care.

Domiciliary care

Many people who receive in-patient care in hospices don't die there. Often they spend around two weeks as an in-patient while their pain control is managed and they then return home for the remaining weeks of their lives, supported by families and the home care team.

Pain management in hospice care is now so well developed that no patient

Continued on PII ▶

◀ *Continued from P1*

need ever die in pain. Unfortunately, this isn't always the case in the community. General practitioners don't always understand fully the principles of pain management and are often reluctant to prescribe the relatively high doses of analgesics that are sometimes used in controlling cancer pain. All too often the good work done by the hospice team is undone by poor GP prescribing.

It is important that good discharge information about medication is provided for all who need to know: the GP, the specialist nurse and any other community nurse involved in the patient's care, and the community pharmacist who will be providing pharmaceutical care for the patient in the last weeks of life.

The patient can benefit from the provision of a medicines care card detailing the doses and times, and giving extra information to enable the patient or carer to cope with special circumstances, such as breakthrough pain.

Patients with cancer who are still being treated actively with chemotherapy will also need symptom control, so the principles of palliative care also apply to them.

Sometimes, people who have reached a stage where their illness is incurable may also benefit from active treatment, so there is often some overlap.

Because medicines are used at all stages, it is crucial to good patient care that pharmacists work with the multidisciplinary team to ensure that medicines are used effectively.

Practice points

Pharmacists should consider if they are doing the following:

- make sure that you can provide information about support services that are available
- talk to the patient or carer about their medicines and their side-effects
- liaise with the GP and the palliative care nurse and anyone else involved to produce care plans for the treatment of the patient, so that drugs likely to be used during the course of the treatment are already in stock in your pharmacy
- liaise with your hospital colleagues who may have specialist knowledge of drug treatment regimens and may be involved in the discharge of the patient from hospital to home
- get to know the pharmacist who provides pharmaceutical care for your local hospice, and liaise with him or her when the patient returns home from a hospice
- use them as a resource for information about this specialist area of care
- persuade GPs to prescribe in small quantities and review frequently to avoid wastage

Emergency cases

Pharmacists must be able to respond quickly to requests for drugs and other items used in palliative care. There are several horror stories of nurses or carers hawking prescriptions round pharmacies only to find the patient has died in the meantime in great pain.

Drugs involved include a range of formulations of high-strength opioid and other analgesics, anti-emetics, rectal diazepam and possibly dexamethasone injection, but will also depend on local prescribing preferences (see 'Drug stock' below right).

There are several local schemes where designated pharmacies across a health authority stock drugs agreed by those responsible for prescribing and administering drugs locally – the hospital palliative care consultant, the hospice medical director and the specialist nurses.

Sometimes the initial stock is funded or there are rotation schemes in place to avoid drugs expiring before they are needed. It is very important that where these schemes exist everyone involved knows what's going on, including community pharmacists (and their locums) who may not participate in the scheme.

The whole package

Packages of care that can be provided for people dying at home must be needs-led. Besides working with other members of the palliative care team in drawing up treatment protocols and advising on medicines use, the key role for pharmacists is around medication management, particularly compliance – making sure that the patient takes the appropriate drugs in the right way.

Drug regimes used in palliative care can be complex and, although oral formulations are preferred, it is not always possible to use this route. So pharmacists must have a good knowledge of different delivery systems, including the use of syringe drivers and nebulisers, as well as being familiar with different dosage forms. A good knowledge of the avoidance and treatment of side-effects is essential.

Drug information sources, such as the NHS drug information centres and the information departments of the NPA and RPSGB can help, as can pharmaceutical manufacturers.

For some patients, aids to compliance, such as medicine reminder charts or compliance packs, may make all the difference, particularly for complicated oral dose drug regimes. Disposable packs, such as the NPA Care-Pak, are useful where all the tablets for one dose can be packed together. The disposable nature of these packs avoids the expensive outlay of some of the other non-disposable systems.

Packages of care should be developed to include discharge planning and care plans for the patient at home. Patients may well benefit from 'registering' with pharmacists who choose to specialise in this area of care.

When the Department of Health started to look at devolvement of funding to local health commissions, special needs patients were identified as appropriate for local funding. Consequently, pharmaceutical services for patients in need of palliative care seem to be a very appropriate starting point for payment for packages of care, particularly if supported by national guidelines for consistency of standards. Alternatively, pharmacists may wish to approach fundholding GPs to sell their services directly to them.

An increasing number of patients are likely to receive care in their own homes and some pharmacies may wish to become centres of excellence for local palliative pharmaceutical care, providing drugs and information and advising on the use of high tech delivery systems. Some may incorporate aseptic facilities into their own pharmacies or will enter into partnerships with others who can provide this when needed.

Interest groups

- The Hospice Pharmacists Association provides support for pharmacists interested in palliative care. It is currently administered by the National Pharmaceutical Association, although membership (£20) is open to any pharmacist. Contact Michelle McDonald on 01727 858687 ext 217.
- The UK Clinical Pharmacists Association has a cancer care special interest group. Contact Pat Kennedy on 0116 277 6999.

The way forward

Excellent changes were brought about by the new funding arrangements for pharmaceutical care for hospices which started in 1991. Although traumatic for some pharmacists at the time, a better service has resulted and both community and hospital pharmacists are now paid not only for supplies of drugs and dressings, etc but also for the pharmaceutical care and advice provided.

Pharmacists are contracted locally for such services and contracts differ according to the local needs and what the pharmacist is prepared to do. But it has been interesting to see community pharmacists, in particular, grow in confidence and build new aspects of service into their renewed contracts.

Last year, a DoH working party produced national guidelines for hospice pharmaceutical care to provide consistency of approach. The Government also produced a document looking to provide a new framework for cancer care. As a result, the RPSGB set up a working party to produce a framework for pharmaceutical palliative care and it will soon publish a document outlining appropriate packages of care.

Drug stock

The following is a list of drugs likely to be needed for patients receiving palliative care (in addition to the more usual stocks and oral preparations which remain the products of choice):

- diamorphine injection in a range of strengths
- water for injection
- midazolam injection
- rectal diazepam
- methotrimeprazine injection
- cyclizine injection
- haloperidol injection
- hyoscine hydrobromide and butyl bromide injections
- phenobarbitone injection
- fentanyl patches.

However, pharmacists should note that the drugs used will vary according to local prescribing preferences.

the world's **FIRST** *oral morphine* **TO LAST** *24 hours*

Once-daily relief from the pain of cancer

From the manufacturers of the MST® range

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Controlled Release Morphine Sulphate BP

Relief tactics

In the second article focusing on palliative care, Mary Allen, a founder member of the Hospice Pharmacists Association and member of the Society's working group on palliative care, offers a summary of drug therapy

OBJECTIVES

- **To understand the importance of appropriate pain control**
- **To be aware of the stepwise approach to analgesia**
- **To be aware of the treatment of associated nausea, vomiting and gastro-intestinal problems**
- **To recognise other problems that need to be considered in palliative care regimens**

Palliative care aims to relieve symptoms rather than cure disease. Its principles apply to a range of diseases, some of which share common symptoms, such as pain, gastro-intestinal problems, respiratory symptoms and so on. Many patients may also have other concomitant illnesses.

All patient symptom control needs should be assessed, including how troublesome the symptoms are, along with other factors, such as the ability to comply with prescribed medication regimes. Non-drug measures and complementary treatments will often alleviate distressing symptoms.

Pain control

The goal of effective pain control is to keep patients free of pain, but still alert, with as few side-effects as possible.

Pain in cancer may have different sources and the cause should be established before treatment. There may be more than one type of pain present, including pain caused by conditions other than cancer.

The oral route is the one of choice, even when the patient is receiving high doses of opioid analgesics. Analgesics should be given regularly, by the clock and not on an 'as required' basis (except for breakthrough pain), and at a dose that is correct for controlling a patient's pain.

Often simple analgesics will suffice and should be used before moving onto the stronger opioids. The World Health Organisation advocates a stepwise approach via the analgesic ladder.

- **Step 1: non-opioid analgesics**

Paracetamol 1g every four hours (to a maximum of 4g daily) may control mild to moderate pain. In patients with swallowing difficulties, dispersible or oral liquid formulations may be used.

Non-steroidal anti-inflammatory drugs are particularly useful for bone pain. Preparations such as Feldene Melt and naproxen suppositories help where swallowing is a problem.

- **Step 2: weak opioids**

Codeine, dihydrocodeine or dextropropoxyphene (alone or in combination with aspirin or paracetamol) may be introduced when paracetamol or NSAIDs no longer control pain. Regular dosing is necessary.

If the usual maximum dose of these drugs is no longer controlling the pain, dosage should not be increased as this increases side-effects, with little effect on analgesia.

A newer drug, tramadol, may be used as a Step 2 analgesic. It produces analgesia both via an opioid-type effect and an enhancement of serotoninergic and adrenergic pathways, blocking the re-uptake of mono-amines.

- **Step 3: strong opioids**

Morphine is the drug of choice for oral use. An approximate conversion for patients moving on from Step 2 is: two co-proxamol tablets or 30mg dihydrocodeine equals 5mg of oral morphine.

Initially, the dose of morphine must be titrated against the pain by giving immediate-release morphine (in liquid or tablets) regularly every four hours (or six times a day). Doses are then increased incrementally until the patient is free of pain. A modified-release preparation can then be given with 12-hourly dosing.

Transfer to modified release tablets simply means giving the same 24-hour dose, divided into two 12-hourly doses. A new once a day slow release morphine capsule (MXL capsule in a variety of strengths) has just been launched.

The last dose of oral liquid/tablet should be given with the first dose of modified release tablet to prevent breakthrough pain, which may still occur occasionally when the patient is stabilised on modified-release preparations. This may be due to a separate pain or to inadequate analgesia. If the pain is often returning before the next dose is due, then the dose should be increased. If something else triggers the pain, then it may be a different pain which requires other analgesic treatment.

Occasional breakthrough pain can be treated with a dose of morphine equal to one-sixth of the daily dose, in the form of Sevredol tablets or morphine solution.

Where the oral route is inappropriate, other procedures may be considered. Transdermal fentanyl patches provide non-invasive analgesia. The rectal route may also be useful. For patients with protracted vomiting, complete dysphagia or who are drowsy or unconscious, continuous subcutaneous diamorphine may be administered using syringe drivers.

Diamorphine is preferred to morphine for this route because of its higher solubility. Conversion rates are 3:1 for oral morphine:subcutaneous diamorphine. Again, it is important to calculate the dose required over 24 hours.

Pharmacists should acquire a full knowledge of the use of syringe drivers and of which drugs are suitable, including incompatibilities where drugs may be mixed in one syringe.

- **Co-analgesics**

Drugs such as antidepressants, anticonvulsants, and corticosteroids are often used in conjunction with analgesics to enhance pain relief, particularly for neuropathic pain. TENS machines,

Practice points: opioid analgesics

- Make sure the patient or carer understands the need for regular, by the clock, dosing.
- MST tablets should never be crushed. If the patient has difficulty swallowing, then an alternative formulation, such as modified release suspension, should be considered.
- Always ensure that a laxative has been prescribed. Explain the need for this to the patient or carer.
- Explain that initial drowsiness associated with opioids will wear off after a few days.
- An anti-emetic may be used if sickness is experienced. The sickness will wear off after a few days and the anti-emetic can be discontinued.
- Increased doses of modified release formulations should retain the 12-hourly regime, rather than increasing the frequency.

acupuncture and complementary therapies may also help.

Nausea and vomiting

Nausea and vomiting can be distressing symptoms and have a variety of causes, including drugs, constipation or bowel obstruction, enlarged organs pressing on the stomach, hypercalcaemia, uraemia, raised intra-cranial pressure or psychological anxiety. Managing the cause will reduce the incidence in some cases.

Non-drug treatment includes eating small portions of foods, cold foods and avoiding foods with strong smells.

Opioid-induced vomiting can be treated using dopamine antagonists, with haloperidol as first choice. Drugs acting on the vomiting centre include the antihistamines and the anticholinergics.

For vomiting caused by problems in the stomach, metoclopramide, domperidone and cisapride are useful, while ondansetron, granisetron and tropisetron control chemo- or radiotherapy-induced vomiting.

Dexamethasone may be useful in vomiting caused by raised intra-cranial pressure, in intestinal obstruction and to relieve the compression in 'squashed stomach syndrome' caused by an enlarged liver.

Subcutaneous infusions of anti-emetics can be used for persistent nausea and vomiting which does not respond to oral medication. Not all the anti-emetics are suitable for this route, and care must be taken in mixing drugs within one syringe.

Acupressure in the form of wrist bands, such as Sea-band, may alleviate symptoms.

Constipation

Constipation is very common in patients with a terminal illness and can be a major cause of anxiety. It is very important to take preventative steps, and to treat symptoms promptly.

Constipation may be caused by disease (bowel obstruction, hypercalcaemia or poor muscle tone, such as in progressive neurological disease), by general debility (poor nutrition and reduced mobility), or by drugs.

Opioid treatment is the commonest cause of constipation in cancer patients. It should be anticipated and prevented by prescribing routine laxatives whenever opioids are used.

Most patients can be managed with a combination of stool softeners and stimulant laxatives, though care must be taken with stimulants which may exacerbate any abdominal pain present. Lactulose is often not well tolerated and can cause flatulence and bowel distension.

Faecal impaction can be treated with glycerine or bisacodyl suppositories, or by phosphate enema. Stimulant laxatives should be avoided where obstruction is present. Sometimes manual evacuation may be required.

Non-drug treatments include maintaining an adequate intake of fluids and fruit, and encouraging as much mobility as possible.

Respiratory issues

Dypsnoea, or breathlessness, is a very distressing symptom for both patients and carers. It may be caused by pre-existing disease, such as asthma, as well as cancer-related causes. Acute onset may be due to a chest infection.

Management of the fear and anxiety are crucial to treatment. Non-drug measures include massage, relaxation and distraction, as well as keeping the room cool and increasing air movements (opening windows) and humidity.

Opioids are used to treat dypsnoea, acting on the respiratory centre to ease the sensation of breathlessness. Morphine may be used in doses of up to a maximum of 10mg every four hours over and above that needed for pain control, without any evidence of respiratory depression. Patients new to morphine should start with small doses (2.5-5mg four hourly) particularly where they are elderly or frail.

Nebulised morphine has been shown to be very effective in some patients, starting with a small dose and increasing as necessary. Only small amounts are absorbed, which suggests that there is a local effect.

Because broncho-restriction can sometimes occur, first doses should be given under supervision with the ready availability of an anti-histamine.

Anxiolytics, such as benzodiazepines, butyrophenones (eg haloperidol) or phenothiazines, may be useful to treat any underlying anxiety. Suggested doses are haloperidol 5-15mg orally or subcutaneously, or diazepam 5-20mg (smaller doses in the elderly). Promethazine may provide a useful alternative, in a single night-time dose of 10-25mg, and occasionally with one or two additional day time doses.

Bronchodilators may be useful if there is concomitant obstructive airways disease.

Cough

Cough may be related to the terminal illness, or may be due to a concurrent illness or chest infection and may be treated with medicines appropriate to the cause and type of cough.

Where opioids are appropriate for cough suppression and the patient is on opioid therapy, cough control may be possible by increasing the dose of the same opioid.

In the last stages of the disease patients may suffer from the pooling of secretions in the trachea and pharynx. This may be treated with hyoscine hydrobromide or glycopyrronium. As far as possible, patients should be correctly positioned, lying on one side with the head raised at an angle.

Eating problems

People who are terminally ill often have eating problems. They may become anorexic, develop altered taste or have difficulties in swallowing (dysphagia). A sore or dry mouth may cause problems.

Food supplements may be given as sip feeds and weak patients may benefit from gastrostomy or naso-gastric feeding. Short courses of prednisolone may help to increase appetite.

Dysphagia may be caused by the underlying disease or by drug treatment. In the latter case, consideration should be given to discontinuing the drug. Appropriate formulations should be used for any other necessary treatment.

Good oral hygiene is essential – teeth or dentures should be cleaned frequently, and the patient should be encouraged to drink plenty of fluids. Mouthwashes such as Corsodyl or Difflam may help as may glycerine and lemon swabs. Sucking pineapple chunks cleanses the mouth and tongue via a natural protease enzyme present. Artificial saliva products such as Glandosane or Saliva Orthana may help with dryness. Any underlying infections such as candidiasis should be treated.

Other problems

Other problems, such as confusion, depression, terminal restlessness and hypercalcaemia, need careful attention. Pharmacists wishing to know more about symptom control will find the references in the previous article on palliative practice.

Benzodiazepines: the answer to chronic insomnia

Picture courtesy of Nytol

Benzodiazepine hypnotics are, on the advice of the CSM, restricted to the treatment of severe or disabling insomnia or for patients in whom sleep problems cause extreme distress. In such cases, the risk of complications is justified by the severity of the problems, but what difficulties are associated with treatment in these circumstances?

Over a 12-year period, a specialist in sleep disorder evaluated benzodiazepine treatment in 170 adults experiencing intractable sleepwalking, night terrors, restless leg syndrome and other sleep disorders. Around 30 per cent had a history of psychiatric disorder and 16 per cent had in the past abused alcohol or drugs.

Treatment with clonazepam or alprazolam achieved complete or near-complete symptom control in 86 per cent of cases. Over a treatment duration of three to four years there was no evidence of significant dose escalation: 71 per cent were taking the same or a lower dose at the end of the study as at the start. No patient was able to discontinue medication without a prompt recurrence of symptoms, but there was no evidence of withdrawal symptoms.

Adverse effects were reported by 16 per cent of patients, including morning sedation and impaired memory and four cases of alopecia. Excessive or unauthorised doses were taken by 1.8 per cent of patients and 2.4 per cent had relapses of substance abuse.

Although this study was neither blinded nor controlled, it does indicate that chronic treatment with benzodiazepines is useful in a highly-selected group of patients. The incidence of complications was low even in vulnerable people with a history of substance abuse.

American Journal of Medicine 1996;**100**:333-7

NSAID protocol saves money

A treatment protocol reduces spending on non-steroidal anti-inflammatory drugs by more than information about costs alone, without significantly affecting patient care, according to a US study.

NSAID prescribing and efficacy were evaluated at three centres. At one, a treatment protocol specified that a trial with ibuprofen or indomethacin must precede the use of newer, more expensive NSAIDs, such as naproxen, piroxicam and diclofenac. Pharmacists encouraged adherence to the protocol.

At the second, a computer program provided information about drug costs every time an NSAID was prescribed. There was no change in practice at a third, which acted as a control.

With the protocol in place for 18 months, the use of expensive NSAIDs was reduced from 34 to 21 per cent of prescriptions – a reduction of 39 per cent. This was associated with a 30 per cent saving on prescribing costs and a reduction in costs from $51 to $35 per 100 outpatient visits.

After adjustment for price changes, this was equivalent to an annual saving of $270,000. There was, however, no change in the proportion of patients prescribed treatment or in the size of cheap or expensive NSAID prescriptions.

Against this must be set the cost of prescribing outside the protocol and the inconvenience of correcting the prescription, estimated at $7.50 per patient affected. When pharmacist and physician time was included, the total saving was reduced to $149,000, or 29 per cent of the budget.

Nine per cent of physicians said the protocol was very bothersome and 2 per cent said it should be discontinued. However, after 40,000 prescriptions had been dispensed, only four patients were judged to have experienced suboptimal pain control due to the protocol.

By contrast, the provision of cost data at the point of prescribing reduced expensive NSAID use by 8 per cent and costs by only 5 per cent. At the control site, costs increased by 2 per cent despite a modest fall in drug prices.

The authors note that until there is evidence of differences in efficacy or safety between NSAIDs, cost is a central consideration. Their protocol was less restrictive than rigid formulary management, they say, and is also applicable to other therapeutic categories.

Journal of the American Medical Association 1996;**275**:926-30

Costing out beta-agonists

Pharmacists and physicians in the US have used claims data to identify the medical costs associated with the use of high doses of beta-agonist bronchodilators in patients with asthma.

Of 20,512 patients with asthma (all over seven years old and taken from four health maintenance organisations with a total population of 675,000), 1,093 patients had been dispensed sufficient beta-agonist inhalers to suggest the use of high doses (more than eight puffs daily).

Although US and European treatment guidelines state that these patients should also be taking inhaled corticosteroids, only one-third were receiving adequate doses; a further third were taking doses that were too low; and the remainder received no anti-inflammatory therapy.

The annual cost of care, including admissions, lab tests and medication, averaged $447 for all patients with asthma. However, in users of high-dose beta-agonists the annual cost was $1,347 and this group, accounting for 5.3 per cent of the asthma population, consumed 16 per cent of total spending. Of this, 55 per cent was spent on medication compared with 44 per cent in all patients with asthma and the excess was largely attributable to the greater use of beta-agonists.

Closer analysis of the high-user group according to use of inhaled steroids showed that higher overall costs were associated with steroid use. Those taking inadequate doses of steroid had more frequent admissions and greater hospital costs.

Surprisingly, high-dose patients taking no steroids had fewest admissions, and physician and A&E visits. Why this was so is uncertain and this group of patients warrants still further investigation.

This study shows that prescription data can provide markers for inappropriate treatment and cost analysis.

Annals of Allergy 1996; **76**:153-8

“Excessive perspiration is deeply embarrassing and **now we’re telling everyone about it**”

What if you couldn’t find an antiperspirant that worked? What if you went on sweating so much that before the day was out you needed a change of clothing? This is the reality for a surprising number of people, as a recent Gallup survey found. In fact, 11% of the women they spoke to were frequently forced to change clothes or cover up to avoid the embarrassment of excessive perspiration. The level of dissatisfaction with existing antiperspirants might also surprise you.

As many as 26% of all women asked were interested in buying a product ‘successfully used by doctors’ – if it was available from their pharmacist. Clearly the market is there, and Driclor Solution is the brand to reach it – especially once our national media campaign begins this summer. As a clinical antiperspirant Driclor Solution provides long term control of excessive perspiration, and even works for problem sweaty feet. Every pharmacist should stock it. Now more than ever.

NEW
Driclor
SOLUTION
contains Aluminium Chloride Hexahydrate

A major advance in the treatment of excessive perspiration

NATIONAL MEDIA CAMPAIGN STARTS THIS SUMMER

Pharmacy only clinical antiperspirant

Presentation: Solution. **Active ingredients:** Aluminium Chloride Hexahydrate USP 20% w/w. **Uses:** Driclor is indicated for the treatment of hyperhidrosis (excessive perspiration). **Dosage and administration:** Apply Driclor last thing at night after drying the affected areas carefully. Wash off in the morning. Do not re-apply the product during the day. Initially the product may be applied each night until sweating stops during the day. Frequency of application may then be reduced to twice a week or less. **Contra-indications, warnings etc:** Ensure that the affected areas are completely dry before application. Do not apply Driclor to broken, irritated, or recently shaven skin. Driclor may cause irritation which may be alleviated by the use of a weak corticosteroid cream. Avoid contact with the eyes. There are no restrictions on the use of Driclor during pregnancy or lactation. Avoid contact with clothing and polished metal surfaces. **Product Licence Number:** 0174/0044. **Pack size and Retail Selling Price:** 30ml bottle, £4.75. **Legal category:** P. **Date of preparation:** March 1995. Stiefel Laboratories (UK) Ltd., Hollspur Lane, Wooburn Green, High Wycombe, Bucks, HP10 0AU.

STIEFEL
Research in Dermatology

Ring versus cream

Urogenital symptoms associated with the menopause – vaginal dryness, dyspareunia, urinary urgency – are common and often persistent, but treatment with an oestrogen cream or pessary is usually effective.

The oestrogen ring, which releases oestradiol at a steady rate for three months, was recently introduced for the treatment of urogenital symptoms, but it is relatively expensive – its basic NHS cost is over £30, almost eight times the cost of a cream.

The two treatments have now been compared in an Australian study in 194 women, all at least two years postmenopausal. Eleven women discontinued use of the ring (nine due to adverse events) and seven withdrew from treatment with the cream (five adverse events).

Vaginal symptoms and dysuria improved or were abolished in 60-80 per cent of women by both formulations and, although the effects of the cream were less marked on pruritus and urgency, there were no significant differences between the treatments.

Vaginal irritation was infrequent but more common with the ring, but the frequency of vaginal bleeding in the two groups was similar. Compliance was 82 per cent with the ring and 76 per cent with the cream and the formulations were judged equally effective at relieving discomfort.

However, 84 per cent of women rated the ring as excellent or good compared with 43 per cent for the cream and, of 27 women who had previously used a cream, all preferred the ring even though efficacy was similar.

British Journal of Obstetrics and Gynaecology 996;**103**:351-8

Mercury allergy in OLR

Toxicity due to mercury leaching from dental fillings has been blamed for a wide range of systemic diseases (eg Alzheimer's disease, multiple sclerosis) and oral lichenoid reactions have been attributed to mercury allergy.

However, the available evidence is contradictory. The latest investigation of oral problems associated with mercury comes from Newcastle, where the role of mercury allergy and the value of replacing mercury fillings with composite resins has been evaluated.

Three groups of patients – 109 with oral lichenoid reactions (OLR); 22 with oral and generalised lichen planus; and 20 with other oral symptoms suspected to be allergic in origin – were given a battery of patch tests.

Ninety-three per cent of patients with OLR had amalgam fillings and 21 per cent of these reacted to patch tests with ammoniated mercury.

In these patients, OLR lesions were more likely to be close to the fillings, or to involve the lips or tongue, than in patients who did not react to patch tests.

By contrast, none of the OLR patients with no amalgam fillings; none of those with generalised lichen planus; and only 3 per cent of those with other oral symptoms reacted to patch tests. There were no differences between the groups in their sensitivities to other allergens.

The study shows that mercury reaction may be an underlying cause of OLR.

British Journal of Dermatology 1996;**134**:420-3

A cuppa cuts stroke risk?

More evidence that antioxidant components of food may protect against vascular disease is provided by a Dutch study on the risk of stroke associated with the dietary flavonoids, beta-carotene, vitamin C and vitamin E.

A group of 552 men aged 50-69 were observed for 15 years from 1970; food intake was characterised by histories taken in 1960, 1965 and 1970. There were 42 fatal and non-fatal strokes during the study period.

The mean intake of vitamins C and E was lower, but not significantly so, than in unaffected men. However, those with the highest intake of beta-carotene had a significantly lower risk of stroke than those who consumed least (relative risk 0.54).

Furthermore, there was a dose-dependent reduction in stroke risk with increasing intake of flavonoids. There was a relative risk of 0.29 in highest consumption against lowest consumption.

The intake of beta-carotene correlated strongly with consumption of vegetables and that of flavonoids with tea and fruit. In fact, tea contributed 70 per cent of flavonoid intake and there was a correlation between increasing tea consumption and decreasing risk of stroke: those who drank at least 4.7 cups per day had only one-third the stroke risk of those drinking 2.6 cups or less per day.

Whether this finding applies to the British cuppa is uncertain: flavonoids probably act by reducing lipid peroxidation and the tea consumed by the subjects was black tea, free of the fat contained in milk which is favoured by the British.

Archives of Internal Medicine 1996;**156**:637-42

Allergic awareness

Some people say they are allergic to drugs without being sure what they mean and, in some cases, without knowing which drug is involved.

A study of 2,500 people attending the A&E department of a large Glasgow hospital were asked about allergies to drugs. Problems with a total of 32 drugs were reported by 9.7 per cent. The drugs most frequently implicated were antibiotics – in particular the penicillins but also co-trimoxazole, aspirin and mefenamic acid. Thirty-eight patients reported an allergy but could not name the drug and 57 could not say what form their reaction had taken.

Of 240 allergies checked with the GP, only 114 were confirmed by the patients' notes. A different drug was implicated in 29 cases.

Although the commonest reaction was a rash (51 per cent of allergies), one in 12 patients reported a severe or potentially life-threatening reaction, such as breathing difficulties or circulatory collapse, and, of these, four could not recollect the drug involved. Only seven patients carried evidence of their allergy, in the form of a warning bracelet or note.

This study reveals that self-reported drug allergy is common but many cases were probably not true allergies or were not documented by GPs. Many people were ignorant of the importance of allergy awareness and should be encouraged to carry warnings.

Journal of Accident and Emergency Medicine 1996;**13**:114-5

Research Digest is a regular series, written by drug information specialist Steve Chaplin MRPharmS, looking at the current developments in medicine

WHITEHALL LABORATORIES

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CHEMIST & DRUGGIST
THE NEWSWEEKLY FOR PHARMACY

This is the 12th in a series of modules designed to accompany the Cambridge Counterpart Pharmacy Assistant Development Programme, provided free to C&D subscribers.

This back-up for pharmacists will enable you to keep one step ahead, so that you will know at what stage assistants are advised to refer to you and the possible action you might take.

This module looks at various factors involved in a healthy lifestyle, such as diet, exercise and giving up smoking.

Pharmacies are playing an increasing role in health promotion. This twelfth module looks at the advice you can give on healthy eating, giving up smoking and other ways people can protect their health.

In this month's Pharmacist's Briefing reference icons are used as follows:


Information


Advice


Treatment


Refer to pharmacist


Refer to doctor or specialist

A similar set of icons is used in the assistants' module.

DIET

The role of the macronutrients – protein, fat and carbohydrate – and the micronutrients – vitamins, minerals and trace elements – is described. A table outlines the functions of vitamins and minerals and foods in which they are found.

The concensus is that a varied diet, rich in fruit and vegetables, should provide all the vitamins and minerals needed to stay healthy. But not everyone eats a balanced diet and much of the vitamin content of food is lost through cooking and storage.

People who might need supplements include:

- The elderly, because of absorption problems, lack of mobility etc.
- Slimmers and others on restricted diets.
- Children who do not eat properly because of food fads.
- Breast-feeding women not eating a varied diet (but they should keep within the RDAs).
- Women planning to conceive should take 0.4mg folic acid daily and for the first 12 weeks of pregnancy. Other supplements are best left to the doctor to decide and vitamin A should be avoided. Pregnant women who take iron should make sure they are taking enough zinc.
- People who do not eat meat, fish, eggs or dairy products will need to take vitamin B_{12}.
- Higher calcium intakes are recommended by the National Osteoporosis Society at particular times, e.g. for growing children, pregnant women, women over 45.
- Convalescents, athletes and people under stress may need more vitamins B and C.
- Asians on a traditional diet may need more vitamin D.
- Smokers need more vitamin C.
- Alcoholics often have a poor diet and impaired absorption and need more vitamin B_1.

Safety

Water-soluble vitamins are excreted if taken in excess, but may still cause adverse reactions. Fat-soluble vitamins accumulate and can be dangerous. Taking too much of one mineral may affect absorption of another.

In particular:

- Over 1g daily of vitamin C may cause diarrhoea, nausea and stomach cramps.
- Prolonged doses of over 1,000mg vitamin E a day may cause nausea, vomiting and abdominal pain.
- Over 200mg a day of vitamin B_6 can cause nerve damage (tingling and numbness).
- Women should not take more than 7,500mcg vitamin A daily (800mcg if they may become pregnant) and men no more than 9,000mcg. Toxicity symptoms include skin swelling, itching, hair loss, fatigue and stomach upsets.
- Signs of vitamin D poisoning (loss of appetite, headache, diarrhoea, fatigue) may occur above 250mcg daily.
- Iron may upset the stomach and is best taken with food.
- Over 200mcg a day of selenium can cause nausea, fatigue, and hair loss.

Assistants are advised to refer:

- **Anyone not sure if they should take supplements** Refer to lists of those most in need and precautions mentioned above.
- **People who ask if supplements will cure specific symptoms.** Professional judgment is required in recommending products which may help (e.g. cod liver oil in joint stiffness, vitamin C in the common cold), without making medicinal claims for unlicensed products.
- **People taking prescription medicines** Vitamins and minerals may affect the absorption of certain medicines and vice versa e.g. zinc and iron with tetracyclines. Calcium reduces absorption of tetracyclines and zinc reduces absorption of ciprofloxacin and penicillamine. Vitamin K antagonises the anticoagulant effect of warfarin, nicoumalone and warfarin. B_6 deficiency may occur with isoniazid. B_6 reduces the effect of levodopa unless a dopa-decarboxylase inhibitor is given. High doses (over 1g) of vitamin C increase serum oestrogen in women on the pill and HRT. See also BNF.

OTHER SUPPLEMENTS

The benefits of garlic and fish oils in preventing cardiovascular disease are outlined, as are possible actions of gamma-linolenic acid products. The latter should be avoided by people with epilepsy.

THE HEALTHY DIET

A healthy diet means eating a variety of foods from the following groups:

- Fruit and vegetables.
- Meat, fish and vegetarian alternatives, avoiding high fat options.
- Bread, cereals and potatoes.
- Milk and dairy foods, using low fat alternatives.

In more detail:

- Half the daily energy intake should come from carbohydrates (particularly complex carbohydrates found in bread, cereals, fruit and vegetables).
- No more than one-third of energy should come from fats and no more than one-third of this from saturated fats.
- Eat at least five portions of fruit and vegetables a day, plus two portions of potatoes, pasta or rice and four slices of bread.
- Limit sugary and fatty foods such as cakes, biscuits and pastries to very occasional use.
- Eat at least two portions of fish a week, one of them oily fish.
- Try not to add salt to food.
- Consume salt-cured, salt-pickled and smoked foods in moderation as some studies have linked them with certain cancers.
- Eat at least 18g dietary fibre a day (a bowl of cereal provides about 6g, two slices of wholemeal bread about 4g).

SLIMMING

Advice:

The best ways to lose weight include:

- Avoid crash diets which can be harmful and lead to rapid regaining of weight lost. Go for a gradual loss of about 1kg a week.
- Aim for an intake of between 1,000 to 1,500 calories a day.
- The emphasis should be on a healthy eating plan which can be followed for life and does not involve banning favourite foods.
- Meal replacements are a convenient way to count calories but do little to re-educate people into healthy eating patterns.
- It is better to eat three small meals a day than one large one. Try not to skip breakfast.
- Take more exercise.
- Joining a reputable slimmers' group helps motivation. Customers may appreciate details of local classes.

ALCOHOL

The recommended safe limits are now 28 units a week for men and 21 for women. One unit is equivalent to half a pint of ordinary beer or lager, a glass of wine, a small sherry or a single measure of spirits.

CAFFEINE

More than 600mg a day is not recommended, as it may cause headache, nervousness, insomnia, tremors and diarrhoea. As a general guide, a 150ml cup of coffee contains about 80–90mg caffeine, instant coffee 60mg and decaffeinated 3mg. A cup of tea or can of cola contains about 40mg. Caffeine supplements may be recommended as a temporary stimulant. Caffeine may also be present in tonics and analgesics.

GIVING UP SMOKING

Pharmacy staff can do a lot to motivate, encourage and sympathise with smokers trying to give up. A detailed support plan is in the Pharmacists Action on Smoking pack (telephone Sophie Stannard on 0171 229 9922).

Advice:

- Pick a day and stop abruptly, don't just cut down.
- Throw away all smoking accessories.
- Avoid tempting situations.
- Take one day at a time.
- If you feel the urge to smoke, distract yourself with other activities.
- Get support from friends and family. Quitting with a fellow smoker helps.
- Remember the rule of three – the craving lasts only for about three minutes, the third day after stopping will be the worst as all the nicotine has cleared from the body, and withdrawal symptoms last about three weeks.

Treatment:

Nicotine replacement products provide enough nicotine to reduce cravings and withdrawal symptoms, but avoid the high blood levels associated with cigarettes. They can help only if the customer has a genuine commitment to stopping smoking.

Assistants are advised to check with the pharmacist to what extent they should be involved in selling these products and to ensure that customers know how to use them.

Nicotine gum must be chewed slowly for 30 minutes when there is an urge to smoke, up to a maximum of 15 pieces a day. It is withdrawn gradually after three months. Smokers who smoke fewer than 20 cigarettes a day should start with the 2mg strength. Those who need more than 15 pieces or smoke more than 20 a day or have their first cigarette within 20 minutes of waking, should try 4mg.

Mouth ulcers are a common withdrawal symptom, not necessarily due to the gum. It can cause hiccups or withdrawal if chewed too quickly.

For nicotine patches, the starting strength again depends on the number of cigarettes smoked and is reduced over a number of weeks. Only one patch should be used at a time and other forms of nicotine avoided.

Adverse effects include insomnia, abnormal dreams, nervousness, dyspepsia, and increased cough (although smokers often find their cough gets worse in the first few days after stopping as the lungs get rid of accumulated rubbish).

Patches which are worn for 16 hours may be more suitable for people who experience sleep disturbances, while the 24-hour patch may be better for those who crave a cigarette first thing in the morning.

Lozenges containing small amounts of nicotine have less convincing evidence of efficacy than the gum and patches.

Nicotine-free aids to smoking cessation include an aromatic inhaler which claims a similar success rate to patches. Capsules containing menthyl valerate, quinine, camphor and eucalyptus oil are other alternatives, but should not be used in pregnancy or breast-feeding.

In aversion therapy, gums or mouthwashes containing silver acetate make the smoke taste foul.

Referred to pharmacist:

- **People who ask for help in stopping smoking**. The Royal Pharmaceutical Society's guide- lines emphasise the importance of the pharmacist's involvement, particularly in the initial consultation. Follow-up support is also important in helping smokers stay stopped. See "Medicines, Ethics and Practice: A Guide for Pharmacists."
- **People using nicotine replacement for the first time**. It is important to advise the correct starting dose to avoid adverse reactions.
- **People with heart disease, high blood pressure, peptic ulcers, thyroid problems, diabetes, kidney or liver problems**. Nicotine replacement therapy should be used with care and only on a doctor's advice.
- **People with chronic skin disorders or reactions at the patch site**. Nicotine patches may be irritating for patients with skin disorders such as eczema, so should be used with care and not on broken skin. If there is a severe or persistent localised reaction or generalised skin rash or itching, the patch should be removed immediately and patients advised to see a GP.
- **Pregnant or breast-feeding women**. Nicotine is teratogenic and passes freely into breast milk so replacement therapy should not be used, unless the GP feels it is less dangerous than smoking.
- **People taking other medicines**. Smoking reduces the effects of theophylline, imipramine, pentazocine and frusemide so smoking cessation may reverse this. Dose adjustments of adrenergic agonists or blockers and less insulin may be required.

SLEEP PROBLEMS

Assistants are advised that the pharmacist might wish all queries about sleep problems to be referred. Trying to find the underlying cause and extent of the problem will enable you to decide the best action.

Treatment:

OTC sleep aids are recommended only as a temporary measure. Diphenhydramine hydrochloride has a half life of three to nine hours, while that of promethazine hydrochloride is 10 to 12 hours. The latter should not be taken on waking in the middle of the night and carries a greater risk of "hangover" effect the next day.

Concurrent use of antihistamines in other medicines and other CNS depressants should be avoided. Side effects include dizziness, headache, nausea, and antimuscarinic effects such as dry mouth.

Alternatives include herbal remedies such as valerian, hops and passiflora; homoeopathic remedies; aromatherapy oils; or acupressure cones worn on the wrist.

Advice:

Sleep hygiene tips include avoiding caffeine, alcohol, excess nicotine and large meals in the evening; trying to establish a regular sleeping pattern by going to bed and getting up at the same time; not having naps during the day; unwinding with a warm bath.

Referred:

- **Customers who have been suffering longer than a week; if other medicines have been tried; continuous early waking.**

Refer to GP. Insomnia may be caused by deep-rooted problems which need to be dealt with by a doctor. Sleeplessness due to bereavement may be helped by counselling and a short-term course of hypnotics. Difficulty in getting to sleep and early waking may indicate depression.

- **Pregnant or breast-feeding women**. Antihistamines are not recommended.
- **People with asthma, epilepsy, glaucoma, prostate problems, difficulty in passing urine, heart, kidney or liver disease, gut obstruction, myasthenia gravis**. Use antihistamines only on medical advice.
- **People taking other medicines**. Antihistamines may enhance the action of anticholinergic agents, tricyclic antidepressants, sedatives or hypnotics. They should be avoided by patients who have taken MAOIs in the previous 14 days.

New Age – Dream or Nightmare?

Graham Phillips, proprietor of the Manor Pharmacy Group and deputy chairman of West Hertfordshire LPC, asks how the current NHS contract can be squared with the New Age vision of pharmaceutical care

A recent *Chemist & Druggist* interview with Sue Ambler, head of practice research at the Royal Pharmaceutical Society, raises more questions than it answers about pharmacists' potential to realise the New Age vision. Does the profession have the will to adapt or will it perish? Do we have leaders with the vision to put the New Age strategy into practice when it is finalised later on this year? Do we have the evidence to convince future purchasers of healthcare of our worth?

I am convinced that practice research will be the key to our success. As somebody once said, let's 'go back to basics'.

Currently, our NHS income revolves entirely around prescription numbers. We are paid (like assembly-line workers) on a piecework basis. The more prescriptions we dispense, the greater our income.

In health-economic terms, we are remunerated for inputs, not outcomes. How does our NHS contract square with a New Age vision of pharmaceutical care, or the trend towards evidence-based medicine?

Just how much our pay structure works against us was brought home to me a couple of years ago when I undertook the dispensing for a local residential home. The home, which was being served by a major multiple, approached me because the centralisation inherent in the multiple did not allow for local liaison, whether with the home or the residents' GP.

Having risen to the challenge, my first task was to trawl through each repeat item for each resident to question whether it was still needed. The result? We reduced the average script numbers for the 32-bed home from 250 to 150 per month.

At an average value of £10 per month per Rx, this represents a saving for the NHS of £12,000 per year, but a loss of dispensing income of around £1,200 per year to me (thoughts of turkeys and Christmas come to mind!).

Against the background of our current offer from the Department of Health: "any increase in remuneration must be met with an equivalent increase in productivity" – or words to that effect – the New Age vision looks more like a nightmare.

Let's face it, we are all aware of ways to reduce the NHS drugs bill, especially by reducing unnecessary poly-pharmacy. But can we trust the DoH enough to take the risk? I can just imagine the DoH spokesman: "The recent reduction in NHS prescription numbers means that pharmacists' workload has reduced by 10 per cent . Our 1999 offer of a 5 per cent reduction in NHS income is therefore more than generous ..." Need I go on?

We obviously need an entirely new contract which reflects the quality of pharmaceutical care delivered, not the quantity of scripts dispensed. Whether that contract should be with the individual pharmacist or with the owner of the business might not be significant. But there are powerful lobbies within our own ranks for whom the current contract has financial attractions.

For a large vertically integrated multiple, the uncovenanted profit on the drugs bought at group discounts makes up for the low NHS fees. By contrast, for the single-handed independent, especially if prescription numbers are low, a move towards remuneration for pharmaceutical care might enable survival.

So what has all this got to do with the Ambler interview? My fear is that if we don't pursue a New Age strategy, we will become an irrelevance to an NHS focused on evidence-based expenditure and demanding definite outcomes. Only through practice research can we demonstrate the added value of our inputs and the health gain that results.

Meanwhile, Nero, in the form of the pharmaceutical establishment, merely fiddles while pharmaceutical Rome burns (to stretch a metaphor beyond reason). That the Society/National Pharmaceutical Association/Pharmaceutical Services Negotiating Committee are only considering working together to fund the practice-research we so urgently need fills me with nothing but anxiety for our future.

Pharmacists have traditionally been reactive creatures, 'the handmaidens of the medical profession'. We could, and should, become equal professionals, integrated within the primary healthcare team. I remain to be convinced that those charged with educating tomorrow's pharmacists have grasped the urgency of the situation. Again, vested interests can lead to intransigence.

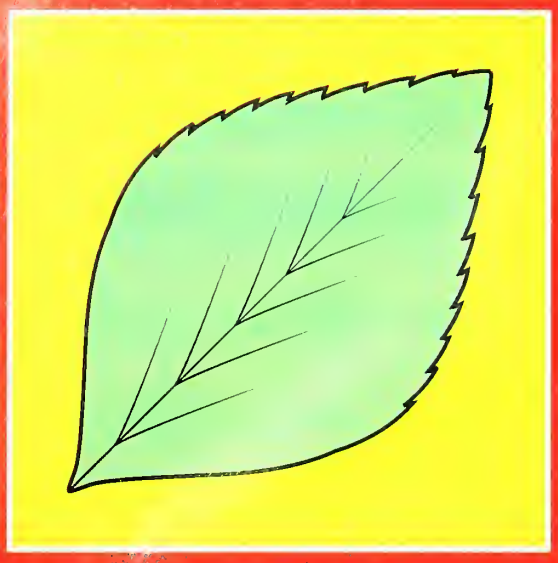
The introduction of the four-year course is a golden opportunity to introduce social pharmacy, and practice research into the undergraduate course. "No!" say the traditionalists. "Pharmacy is a science degree, not clinical/professional training." Implicit in this argument is that practice research is not true science. A careful reading of the Ambler interview will soon disabuse one of that misconception!

Where does all this lead us? I finish with my 'wish list for a pharmaceutical future'.

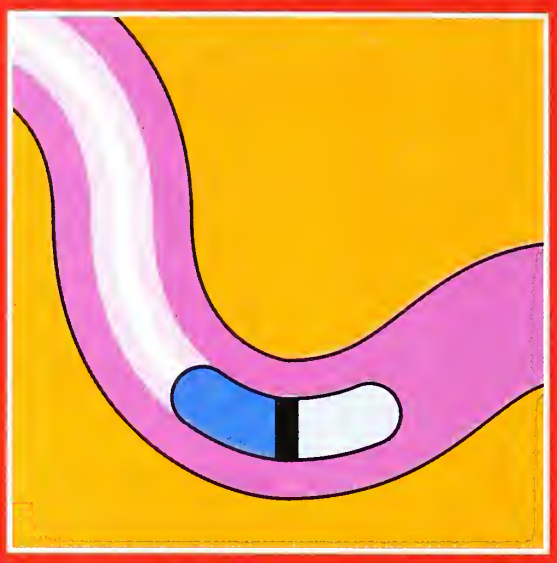
- The threads of the New Age strategy will be drawn together by the Society.
- We must urgently invest in practice research, both to quantify our current contribution to the nation's health, and to demonstrate what a move to true pharmaceutical care could offer.
- The selection and education of tomorrow's pharmacists must take place with an eye towards our New Age strategy.
- If PSNC is not to become an irrelevance, it must abandon its collective security blanket. The comfort and security of prescription numbers as the only basis for dispensing must be discarded. Its place will be taken by the relative uncertainty of clinical outcomes and managed care.

If PSNC is not to become an irrelevance, it must abandon its collective security blanket

A vision without a strategy is ultimately no more than a daydream. The New Age strategy for pharmacy must embrace all levels within the profession from educators to community and hospital pharmacists and from the Society to PSNC.



NATURAL CONCENTRATED PEPPERMINT OIL



IN SUSTAINED RELEASE TO GET TO THE PROBLEM

WHERE IT WORKS IN TWO WAYS

TO RELIEVE THE SYMPTOMS.

At last. A whole new approach to Irritable Bowel Syndrome.

Colpermin, one of the most widely prescribed treatments for Irritable Bowel Syndrome (IBS) is now available in a new OTC pack.

Natural Peppermint Oil. Colpermin contains concentrated natural peppermint oil, clinically proven to relieve the symptoms of IBS. An enteric coating combined with a sustained release formulation delivers relief directly to where it's needed most.

Dual Action Relief.

1. Colpermin relaxes the muscle in the bowel wall to relieve painful spasms.
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By restoring regular bowel movements Colpermin relieves the symptoms of IBS.

A New Approach to Pharmacy Support.
Make sure you don't miss a unique opportunity:

- A new approach in support materials
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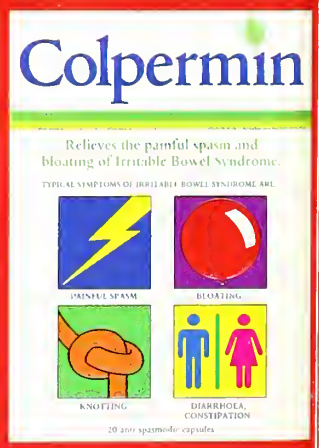
- A new approach for pharmacy

Look out for further details of our consumer launch activity week commencing 24 June 1996.

Colpermin



Relieves the painful spasm and bloating of Irritable Bowel Syndrome

Facts and figures on plastic

Peter Willis has done good solid homework in the article on payment by credit and debit cards (*C&D* May 12) and his comments on the growth of plastic are particularly pertinent. May I add some information to highlight differences between the typical community pharmacy and retailers in general?

The average transaction value for credit cards presented in pharmacies is more likely to be £20 than £45, and debit cards come in at £2 to £3 lower. Without this knowledge, it is difficult for pharmacists to gauge whether or not it is worth going into plastic.

Barclays Merchant Services 'averages' are for UK card services as a whole – community pharmacies are very unlikely to achieve the 1.6 per cent on credit cards or 16p on debit cards. The likely figures are 3 to 5 per cent and 20p to 30p, respectively. On top of transaction charges, terminal rental adds a fixed sum of £5-£25 (depending on the transaction charge rates) to the monthly bill.

National Pharmaceutical Association members can, of course, get more details direct from me at the NPA.

Trefor Williams
Business services manager, NPA

Swamped by patient packs

I can understand **Xrayser's** frustration regarding the introduction of the first wave of patient packs, in particular corticosteroids. However, in his plea for slim packaging, he appears unaware that this has been available since late 1995. On December 1, 1995, CP Pharmaceuticals led the way with the introduction of prednisolone 1mg and 5mg, 28-tablet blister packs in small cartons.

David Browser
Sales and marketing director, CP Pharmaceuticals

Glaxo: here to help you

I noted with interest **Xrayser's** comments in *C&D* May 4, regarding recent market research activity carried out by Glaxo Wellcome.

Recognising the changing role of the primary healthcare team, in which community pharmacists are playing an important role, Glaxo Wellcome recently began extensive market research.

The questionnaire referred to in the article was aimed at gathering quantitative information and was tested by a panel of community pharmacists.

We have been encouraged by the high and rapid response to this initiative and believe it will help us make future contact with community pharmacists more efficient, relevant and helpful.

The research is part of an ongoing process aiming to provide pharmacists with a high level of service for Glaxo Wellcome products.

Dr Maureen Devlin
Customer marketing, Glaxo Wellcome

Whose side is the NPA on?

I was interested to read the views of the National Pharmaceutical Association in *C&D* (May 4, p601) on the natural evolution towards bigger and fewer pharmacies.

As an NPA member for 19 years, at last I am beginning to question whether the NPA was formed to protect and help me from adversity or to advocate and support views that benefit only large contractors.

How useful, important and valuable a point of contact are small pharmacies? To date, the NPA has not undertaken any survey to find out how small pharmacies perform on personal service, ease of accessibility and emotional support to patients at the point of collection.

Why doesn't the NPA recognise this important issue and represent the views of small pharmacies which have supported it since its inception. Isn't it time the NPA submitted a case for small independent pharmacies to the Government?

The NPA is clearly playing a game with words. Some time in the future it will say that it did make its views and intentions clear and, on the other hand, when challenged it will say it is an opinion.

Is the NPA disguising its true intention? With these sort of words, one wonders which way the nominees of the NPA votes at Pharmaceutical Services Negotiating Committee meetings?

Does the NPA fully support the emergence of a situation that will benefit larger contractors at the expense of the smaller contractors?

Under Mr Major's Government, I understand only 'Major' businesses or institutions matter. I call this 'Majorism'. It appears that the NPA suffers from 'Majorism' and is only keen to support members who are multiples.

I will remember the 75th anniversary celebration of the NPA as one in which it clearly ditched its small independent contractors.

R L Hindocha
Managing director, Camrx Group

NPA's changing emphasis

I was interested to read of the National Pharmaceutical Association's response to Pharmacy in a New Age, suggesting possibly fewer pharmacies (*C&D* May 4, p601).

I can quite understand the Department of Health, or even possibly the Pharmaceutical Services Negotiating Committee seeking a reduction in pharmacy numbers, but would never in a million years have thought that an organisation set up 75 years ago to protect independent pharmacists' interests would want to reduce its membership.

Since 1990, when the NPA changed its emphasis from independent pharmacists to pharmacy contractors, its attitude has become similar to the Company Chemists Association – to let independents go to the wall. This becomes evident when one sees the NPA nominees on PSNC supporting the direction of the Committee. Maybe it is time for the NPA to amalgamate with the CCA?

If the majority of independent pharmacies shut, will the CCA want to be part of the NPA, when its members have their own arrangements for insurance and buying in items the NPA currently sells to its members?

Any so-called rational distribution will occur at the expense of independents since they are heavily dependent on the NHS remuneration, while the multiples use pharmacy to support their other retail activities.

Jay Patel
Romford

The National Pharmaceutical Association responds: "The NPA Board, which is comprised mostly of independent pharmacists, does not advocate the abolition of small pharmacies, but predicts that in the future there might be amalgamations where there are clusters of pharmacies in small geographical areas. If this happens, the Board is determined that small pharmacies should not be disadvantaged but encouraged by financial incentives, to [illegible] forces. In this way, independents will flourish in the future.

Future positive

Although many pharmacists see an uncertain future, the outlook for pharmacy retailing should be positive. The Ulster Chemists' Association heard how the independent can respond to outside challenges and enter successfully into the next century at its third annual conference, entitled 'Pharmacy retailing in the year 2000'

Keynote speaker Barry Andrews

The UK is not alone in facing the problems of rising productivity in pharmacy coupled with reduced remuneration.

However, the message aimed at pharmacists attending the Ulster Chemists' Association conference in Newcastle, co Down, last Sunday, was to consider what they can do individually and collectively which will allow the profession to enter the next century with a positive outlook.

"We must not allow those who do not wish to change to stand in the way of those who do," said Barry Andrews, managing director of Moss Chemists, in his keynote address.

Warning of the impact of large supermarkets, which have yet to open in Northern Ireland, he said: "You ain't seen nothing yet! Sales of traditional pharmacy business lines are moving over to grocers at a rate of 4 per cent per annum."

He saw three possible ways forward for pharmacy in the future:

- 'managed decline', which accepts declining margins with static income in real terms and no investment
- 'smarter and sharper', where existing business is driven even harder
- 'developing business', where by undertaking new services new income streams can be obtained.

Pharmacists could increase sales by making the shop more inviting or offering incentives, such as a mother and baby discount card.

"Do you micromarket?" he asked. "Do you stock the precise ranges and products that people really want to buy – not what you want to sell them?"

"Well trained counter staff will generate at least an extra $5,000 per year of sales per assistant compared to those who are untrained," he said.

Mr Andrews warned that products may be being sold too cheaply. He advised: "Don't compete on price unnecessarily – you are only giving your hard-earned margin away."

Pharmacists could develop their business by undertaking new services, he felt. "You have to find new ways to add value to the healthcare chain and find ideas to move significantly beyond the traditional role and function of a pharmacy – but preferably in ways that competing people or bodies cannot.

"A more strategic suggestion is to gradually redefine the pharmacists' role as the nation's medicine manager," he continued. "Surely, with our expertise and working with the GPs, we can save at least 2 per cent or 22 per cent on the cost of drugs. Splitting these savings would be a pretty good income generator. The phrase 'fundholding pharmacy' comes to mind.

"Medicine management should be attractive to a considerable number of community pharmacists. With some training, they will have the ability and confidence to offer this service to individual GP practices or health boards.

"Customers like patronising those pharmacies that do provide extra professional services. They probably expect us to be undertaking many of these new roles and we are simply fulfilling their expectations – a critical success factor if ever there was one."

Pharmacists were also encouraged to discuss mutual problems more frequently with each other to motivate and learn by collective experiences.

"I am convinced that this isolation is often the root cause of our hesitation to progress and our apparent apathy. Overcome that and pharmacy 2000 looks very attractive," concluded Moss' managing director.

Time for a change?

Negotiations with the Department of Health may have to take on a new form as the current format is less than successful.

"I do believe we need a new way of negotiating – the adversarial approach doesn't work," said Barry Andrews, who is also a member of the Pharmaceutical Services Negotiating Committee. "A partnership approach has to be the way forward now. There have to be tremendous gestures of good faith on both parts."

In a question and answer session, concerned pharmacists questioned the effectiveness of their negotiators. Mr Andrews, while welcoming the idea of having professional negotiators, raised several questions himself.

"I would be quite happy to have a professional negotiator, but what are their tools? Who will these negotiators be? What will the sanctions be?"

He added: "I think that the pharmacy service is a national treasure and I believe the DoH recognises that. If pharmacies were closing down, then the DoH would sit up and listen – then the PSNC might have a tool."

Mr Andrews referred to the research the Office of Fair Trading had done into the issues surrounding Resale Price Maintenance. "Government bodies will – for the very first time – have access to an official independent report about our [pharmacy] financial status. I am convinced this should be an invaluable negotiating tool. At least in the future we can argue on the basis of agreed facts, not simply fiction."

Mr Andrews added that the Department was interested in pharmacy "as it believes we are the best people to manage [health] costs".

Less is more

Numark's David Wood

A healthy OTC business and good presentation are vital for the independent pharmacy.

This was the message from David Wood, marketing director of Numark. He suggested that pharmacists should concentrate on a core range of goods if they were to compete.

The self-medication market was not showing growth as expected, and there was an "alarming" increase in grocery sales, especially analgesics. In order to defend pharmacies' current market share it was necessary to "attack".

"Pharmacists cannot afford to just abandon the current categories we have within pharmacy. We have to make a phased change from toiletries to healthcare. We have to become more healthcare orientated," he said.

Pharmacists were advised to "stock the products that sell". To this end, Numark members would receive data on a core range of products, which, with their local knowledge, would enable them to build up sales.

Stores should have a range of KVIs (known value items). These are products that the public know the price of and are aware if they are not getting a fair deal. "You will make your margin on the secondary lines where the public is not sure of the price," said Mr Wood.

He revealed that recent research by Numark on shelf barkers indicated that three or four barkers per category could significantly increase the sales, although the lines promoted may not necessarily be on offer. The public "perceives" value for money.

"Get behind a brand and support it," advised Mr Wood. "The shop fascia and the brand image work together. It builds loyalty among customers who realise that they can only get a Numark brand at a Numark store."

Peter Wright, president of the Ulster Chemists' Association, was pleased that 100 delegates, representing 20 per cent of the UCA, were able to attend the conference

EPoS for all

EPoS is a product that should be in every pharmacy, said Maria Mackin, EPoS manager for S McLernon.

Ms Mackin said: "It's not true at all that pharmacy is behind with technology." Community pharmacy was "way ahead eight or nine years ago", when it was one of the few businesses that was sending data orders by phone.

The worry of cost was also eased as Ms Mackin explained that, by having an EPoS system, within a few months the machine would have paid for itself by reducing stock levels. The system could identify slow movers and even bad areas within the shop layout.

Besides being able to record sales and movement of stock in and out of the premises, EPoS also acted as a management tool, and could work to the pharmacist's advantage when buying goods. With the history of sales of a product or range of products, a manager could buy what was wanted for the shop rather than what the sales representative told him was needed, she said.

"EPoS is a tool designed to help you. Computers in dispensaries have taken pharmacy a long way down the road. EPoS is just the next stage," Ms Mackin said.

Town centre management needs greater support

Retailers do better in towns where local authorities and businesses are working together to promote the town centre, a national survey of principal High Street retailers commissioned by Boots the Chemists has confirmed. But only three out of 17 town centre management (TCM) schemes surveyed had half of local businesses signed up and many had less than 20 per cent of traders supporting them.

Urban Management Initiatives of Huddersfield, which conducted the survey, believes that the effect of out of town development on High Street shopping appears to be more marked than previously estimated, particularly in the South East. A number of TCM schemes have, however, had success in minimising the effect of such developments and in re-invigorating town centres.

John Lockwood, of Urban Management Initiatives, tells *C&D* that commitment to TCM schemes is unlikely to be expensive for smaller traders. Small independents ought to be saying "What is our policy?" and "What are we going to do to strengthen our town?", he suggests.

Mr Lockwood says American main street schemes are achieving 60 per cent trader participation. They could involve measures such as a commitment to improving customer care through improved training or an undertaking to improve shop frontages.

Chris Hollins, of Boots and vice chairman of the Association of Town Centre Management, says: "Everyone involved with the town centre management movement should take heart from the findings and recognise the need for continued and improved action."

The survey, which examined the changes in sales figures of High Street stores between 1990 and 1995, as well as confirming the positive effects of town centre management, revealed a gap in trading performance between towns in the north and south of Britain.

Stores in Scottish towns and in the north of England performed considerably better against inflation than stores in the South East.

Information was provided by 22 principal retailers, with detailed input from Boots and Marks & Spencer. In all, 323 stores in 46 towns – 17 of which had had town centre management schemes operating for at least two years – provided input.

In towns with an effective TCM scheme, 71 per cent of stores achieved higher takings than stores in control towns. TCM centres which performed best gave priority to, and reported no significant problems with, access and parking. However, taking the 46 centres as a whole, store managers reported that takings in one-third were being damaged by access problems, parking charges and by access controls.

The effectiveness of many schemes was limited by lack of sign-up and commitment from local businesses. Lack of funding meant that issues such as access, and ease and cost of parking were not being addressed.

Over 60 per cent of stores in the total sample failed to record sales growth above the rate of inflation during 1990 to 1995 and actual takings in almost a quarter of stores were less in 1994/5 than in 1990/91. Takings of stores in towns in the South East and to the north and west of London slumped – in these areas the percentage of stores not keeping pace with inflation ranged from 73 per cent to as high as 96 per cent. Takings in stores in the South East fell to 20 per cent or more below inflation in almost half. One-third of stores in Scotland achieved 10 per cent or more above inflation.

There are plans to repeat the survey covering a larger number of TCMs next year.

BOC Group profits up 12 per cent

BOC has reported half-year pre-tax profits to the end of March, 1996, of $217.4 million, up 12 per cent on the same period last year. Earnings per share increased by 11 per cent to 27.85p and turnover increased 10 per cent to $1,976m. A second interim dividend of 13.5p per share will be paid on August 1.

The Group's healthcare division, however, did less well, with sales of Forane anaesthetic gas under pressure. Profit was down 9 per cent to $28.4m and turnover down to $249.5m. The medical devices division achieved a good profit improvement in the first six months and the international marketing organisation established in the past two years is starting to produce encouraging results.

The vacuum technology and distribution services business had profits for the six months up 39 per cent and turnover up by 27 per cent.

Astra to enter NY Stock Exchange

Astra has reported an 11 per cent rise in first quarter profits and plans a listing on the New York Stock Exchange on May 23. Pre-tax profits were Skr3.44 billion, up 11 per cent from Skr3.1bn in the same period last year. Group sales rose 8 per cent to Skr9.34bn from Skr8.65bn, driven by a 15 per cent increase in Losec sales.

The results were affected by a higher value Swedish krona in the period. The company says group sales at constant exchange rates were up by 16 per cent.

The company's annual meeting on May 13 approved a dividend of Skr3 per share. Chief executive Dr Håkan Mogren referred to future products for 1996 and beyond, included among them were Naropin, a local anaesthetic and analgesic, Entoroct, for inflammatory bowel disease and the Oxeze Turbohaler.

Zeneca shows strong first quarter

Zeneca has sold its loss-making textile colours business to BASF for up to $138 million in cash. The disposal completes the restructuring of its specialty chemicals division.

Zeneca Group's chairman, Sir Sydney Lipworth, told the annual meeting last week that confidence for 1996 was underpinned by the group's strong performance in the first months.

"Pharmaceuticals and agrochemicals have both produced first quarter sales that are well ahead of last year and ahead of our budgets. This has been something of an exceptional start," he said.

But he warned that development and launch costs had risen as new products were brought to market.

Oxford Glycosciences raises £13m

Oxford Glycosciences, the drug discovery group, has raised $13 million in a private financing round. Chairman G Kirk Raab predicts: "We expect we will be ready for a stock market flotation during 1997."

OGS will use the funds to support commercialisation of drugs discovered through its competency in glycobiology. The company, which was founded in 1988 and was Oxford University's first commercial venture, is a leader in carbohydrate engineering. It is currently applying this technology to discover small molecules for the development of drugs in cancer, inflammation and infectious diseases. Its lead product is a novel molecule to treat cancer of the liver.

Shadow Welsh affairs health spokesman Rhodri Morgan recently spent half a day at Bayer Diagnostics Manufacturing in Bridgend, South Wales, on a fact-finding tour. Pictured (left to right) are: Paul Morris, Bayer's personnel manager; John O'Neill, the company's plant director; Rhodri Morgan; and David St George, Bayer's healthcare relations manager

Knoll numbers

Knoll of Nottingham is changing its telephone and fax numbers on May 26 to 0115 912 5028 and 0115 912 5069, respectively.

Chiroscience raises £40m

Chiroscience has confirmed details of a successful placing and open offer, raising £40 million to fund further research into its range of single isomer drugs, and the purchase of the pilot-scale development centre of Resolution Chemicals, a subsidiary of E Merck, for £5.5m.

Allergan merger off

Talks on a $2.5 billion merger between Pharmacia & Upjohn and Allergan have been called off.

Hadley Hutt module enables targeting of customers

PILLS Mailshot, from Hadley Hutt Computing, is designed to allow community pharmacists to target their customers with information on special offers or services relevant to specific customers.

The marketing module is designed to work with data from the PILLS patient medication record system. It can generate mailing labels for patients suffering from a specific type of condition or taking a particular class of medicine.

Alternatively, general information, such as the implementation of a prescription delivery service, can be put out to the full patient list.

Retail strengthening trend confirmed

Retail sales volumes increased in April at a slightly greater annual rate than in March, but still well below retailers' expectations, according to a Confederation of British Industry survey.

Chemists saw a pick up in the rate of sales growth following a slow down in March.

Alastair Eperon, chairman of the CBI's distributive trades survey panel, says: "Retailers remain confident trade will further pick up in May, but the experience of the past two months suggests the pace of growth may be more modest than they currently expect."

Wholesalers' sales volumes rose sharply for the third successive month. Stocks remained excessive in relation to expected demand and had built up since the start of the year.

The strengthening trend was confirmed by the British Retail Consortium Sales Monitor for April. This showed an annual increase in the like for like value of retail sales of 0.4 per cent. However, the change in the timing of Easter distorted the figures. Taking March and April together, says the BRC, the average weekly like for like value of sales was 4.4 per cent up on a year ago. This represented a modest strengthening from the average growth rate of 4.0 per cent recorded over the winter months and a significant improvement on the 2.7 per cent average like for like sales growth last year.

BRC reports that the weather had a significant influence on 'chemist and beauty' performance in April. Relatively high sales of cough and cold remedies were experienced and vitamins continued strongly. Sales of sun preparations reflected the absence of warm weather, although sunglasses fared better. With windy conditions, skin care products were in demand.

Lloyds replaces trucks

Lloyds Chemists has taken delivery of 181 new Scania trucks to help meet the group's distribution requirements. The £7.5 million order with Kelly Trucks of West Bromwich is the largest single order ever placed with a Scania distributor in the UK. The deal involves the purchase of the old Lloyds' fleet and a five-year maintenance package.

Vantage test system

Vantage has launched a mini CM² front-shop management system to meet the needs of customers who would like to test it before committing themselves to the whole programme. CM² One to One subscribers can choose from 21 product groups merchandising plans priced at £10.

Network Management move

Network Management has moved premises and can be contacted at Victoria House, Victoria Road, Aldershot, Hampshire GU11 1DB. Tel: 01252 351100.

Glove purchase approved

At an extraordinary general meeting on May 9, shareholders of London International Group approved the acquisition of US medical glove manufacturer Aladan Corporation. LIG expects to meet US conditions and complete the purchase shortly.

Bioglan goes plc

Bioglan Pharmaceuticals has become Bioglan Pharma plc, reflecting the group's plans to become a listed company within the next two to three years. The Hitchin-based company has subsidiaries in the UK, Ireland, Denmark, Sweden and most recently the US, and a portfolio of over 40 products.

Case adjourned

High court procedings in a case brought by Ideal Health against Lloyds Chemists subsidiaries Farillon and Barclays got underway on Tuesday but were almost immediately adjourned at the request of the defendants following discovery violations.

Telephone banking

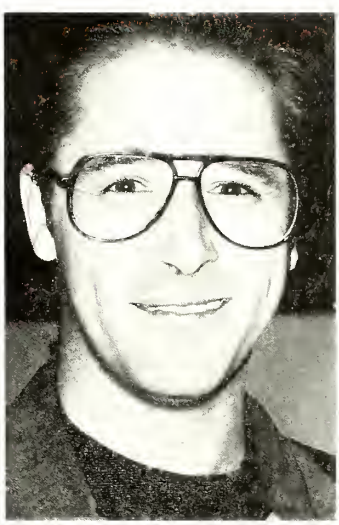
Barclays has launched a telephone banking service for small businesses. Initially for existing sole trader customers, Barclays Businesscall promises long opening hours, a local rate telephone number, and a passcode and identification for each customer.

Ethical limits investment to core drug delivery business

Ethical Holdings is to concentrate on its core drug delivery business. Its board believes the group is best served by limiting investments outside its rapidly expanding drug delivery sector, particularly its progress in the US.

It has therefore appointed Baring Brothers to advise on its strategic options regarding non-core operations.

Ethical will continue to aim to drive part of its growth through acquisitions allied to its drug delivery activities.



Paddy Chubb has been promoted to the post of sales director at L Rowland & Co 18 months after joining the company as business development manager. Mr Chubb has been responsible for growing the independent pharmacy sector for the company and in setting up a twice daily delivery service to South Wales from the company's new warehouse near Cardiff. Commenting on the Wrexham-based wholesaler's continuing development, Mr Chubb says: "We will be expanding our services even further. We have a number of new and innovative ideas."

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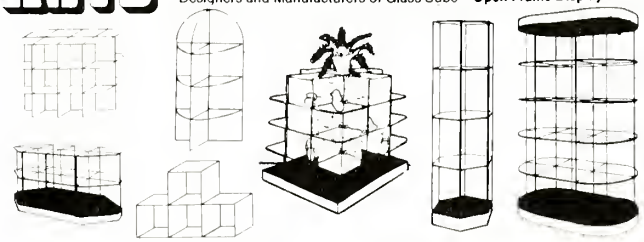

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SPEAKING OUT

Gill Dascombe describes herself as 'a jack of all trades', but the qualifier, 'and master of none', does not hold true. Last November, she was a finalist in *The Times* Preacher of the Year Award. Charles Gladwin went North to talk pharmacy and religion

As a pharmacist, it seems Gill Dascombe has tried her hand at everything: community, hospital, research, teaching and industry. But what she enjoys most is helping the public.

It was this that persuaded her to leave Sanofi in the late 1980s and return to being a locum. More importantly, it gave her the chance to devote time to being a lay worker and a preacher, a role in which she has received more than local approval.

Although her father was a Methodist minister, becoming a lay preacher was not an early ambition. "I had no desire to follow in his footsteps, but the feeling grew inside me and I felt I wanted to give it a try," she explains.

So, in 1987, after two years of study and exams, she became a fully-accredited lay preacher. She started off by taking services once a month in Stockport, and in the suburbs of Hazel Grove or Offerton, her home town. She now preaches regularly and helps teach others.

Gill's style of preaching, she says, "is to be just me, rather than be authoritative. I am not a 'thee and thou' person". With the congregation's thoughts possibly on the Sunday roast, she adds: "You have got to be understandable and communicate in a special way that'll get through straight away."

Subject matter for her sermons can be drawn from any source. Bible stories and personal experiences form the basis for many, but she adds that not knowing who might be in the congregation can cause the odd hiccup.

"I got carried away once, talking about the development of babies, but there was a consultant paediatrician in the congregation." She was told afterwards that she got the facts "slightly wrong".

Her success in *The Times* Preacher of the Year Award is something she says she "never expected in a million years". Persuaded by husband Mike to submit sample sermons, she reached the final, held last November. Finalists were each asked to preach in a service at St Pancras Church, London.

Among the judges listening to Gill speaking about the first Beatitude were politician John Gummer and broadcaster/-atheist Ludovic Kennedy. She doesn't think Mr Kennedy warmed to her style, even though he listened intently. A pity, as she believes good preaching should "ring some bells, even with atheists".

She stresses that the event was not a competition, but a way of promoting and raising the awareness of preaching. To this end, it seems the scheme has worked. As well as extensive coverage in *The Times* and local press (resulting in a thick scrapbook of cuttings), she says she is regularly recognised and asked about the Award by people in the local shops.

> The Gospel is more effectively communicated by an ordinary person, not some official

One of the other five finalists was an Anglican trainee woman priest. On this, Gill says: "There is still prejudice against women. A lot of people still prefer to see a man in the pulpit – it's appalling. We're living in the present now."

A science background perhaps surprisingly adds to her faith. "Science is thrilling – it's part of the wonder of the world. There is a perceived conflict between science and religion. It is no use pretending scientific discoveries haven't happened – they have, but I find no difficulties with the two." She remembers learning the periodical table: "All that wonderful order – it was quite a religious experience."

She continues: "There is conflict when the Bible is taken word for word. It is not a textbook of cosmology, but a book of faith." Disapproving of the arguments of creation versus evolution, she adds: "I could still believe in a literal seven-day creation, but it wouldn't affect my day to day life."

But spreading the word is not done just on the Sabbath. Her role as a lay worker gives her "a chance to do more than 'hit and run' preaching", which she defines as: "Hitting the congregation with a service and then not seeing them until the next Sunday morning."

Her lay work in Macclesfield has allowed her to organise day-long 'mini retreats'. She believes these retreats offer people "a chance to stop and think things through about themselves. There is no silence in modern life. People cram noises into their head so they don't have to stop and think".

Gill is also involved in a scheme visiting secondary schools to create interest in the church. Rock music is included in religious education lessons "to get the kids interested". For those who are, she gives Bible classes and will put them in touch with a local church.

As to the future, she says she will always be a preacher, but does not want to be a minister or 'clergy person'. "The Gospel is more effectively communicated by an ordinary person, not some official," she explains.

And finally, to add to that 'jack of all trades' sobriquet Gill gives herself, there is the possibility she will turn her hand to writing. A book of meditations may eventually be written, if, she says, she ever finds the time in her busy schedule.

COMPETITION

Enter the Clarityn Allergy/ Clariteyes best window display competition

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£1,000 of M&S vouchers
Plus 500 'Summer in the City' cassettes

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For supplies of point of sale material, telephone Schering-Plough Consumer Health on 01707 363739.

The winning pharmacy will receive £1,000 worth of Marks & Spencer vouchers to share among the outlet's pharmacists and assistants. There will also be 500 runner-up prizes of the Clarityn Allergy 'Summer in the City' cassette featuring ten summer music tracks by original artists such as The Kinks, Steve Harley, The Proclaimers, and Katrina and the Waves. Each member of the runner-up pharmacies will receive their own personal copy, so make sure you fill in all the details on the entry coupon correctly.

Rules

1 Only entries from bona fide pharmacists and pharmacy assistants submitted on the coupon accompanied by a colour print will be accepted. **2** There will be a prize of £1,000 worth of M&S vouchers to be divided up at the proprietor's discretion. There will also be 500 runner-up prizes of Clarityn Allergy 'Summer in the City' audio cassettes. **3** Entries must be received by July 16 and judging will take place on July 23. **4** Proof of posting cannot be taken as proof of receipt. **5** The winners will be notified by the local Schering-Plough Consumer Health representative. **6** No purchase required to enter the competition. **7** The names of the prize winners will be available from Schering-Plough Consumer Health after July 24. **8** No correspondence will be entered into. **9** The judges criteria for selecting a winner will be: impact of the display, originality and best use of Clarityn Allergy and Clariteyes merchandising. The judges' decision is final. **10** Schering-Plough Consumer Health reserves the right to publish the winners' names. **11** The photographs will not be returned. **12** Entry into the competition is taken as acceptance of the rules. **13** The competition is not open to employees of Shering-Plough or Miller Freeman, their agencies or relatives.

Competition

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Position .....

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